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As a reviewing and abstracting journal, *Rehabilitation Literature* identifies and describes current books, pamphlets, and periodical articles pertaining to the care, welfare, education, and employment of handicapped children and adults. The selection of publications listed and their contents as reported is for record and reference only and does not constitute an endorsement or advocacy of use by the National Society for Crippled Children and Adults.

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REHABILITATION LITERATURE

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REHABILITATION LITERATURE

Article of the Month

A Concept of Rehabilitation

Herbert S. Talbot, M.D.

About the Author . . .

Dr. Talbot has been chief of urology at the Veterans Administration Hospital, West Roxbury, Mass., since 1953 and is a lecturer in urology at Boston University and a clinical associate in surgery at Harvard. He is chairman of the World Committee on Spinal Paraplegia, International Society for Rehabilitation of the Disabled. During the war years 1941 to 1945, Dr. Talbot served in the Royal Canadian Army Medical Corps. He received his M.D. degree at Columbia University College of Physicians and Surgeons, New York City, in 1928. Dr. Talbot is a fellow of the American College of Surgeons and a member of the American Medical Association and of the American Urological Association.

THIS LECTURESHIP and this hospital in which it is endowed are symbols of something fine and strong in America and American medicine, the self-sustaining community, pouring its own productiveness into the stream of our national life and reaching out to every corner of the land to maintain the associations that strengthen us all. But it is only fair to warn you at the outset that I bring you no announcement of great advances, so-called, no magic new drugs, no bold new technics. Instead, I shall try simply to share with you some of my reflections arising out of an experience that has been exciting and rewarding.

As it has seemed important to me, so I think it will seem to you, because it concerns itself with an impulse that lies at the heart of our calling, the untiring urge of the physician to make men whole. Further, it carries that impulse into an area of our responsibility that should be peculiarly the province of the local community. Nor is that claim invalidated by the fact that the personal experience upon which it is based was full-time work in a federal service. For just as the chief function of government is to secure the lives and prerogatives of individuals, so it must be the aim of federal medicine to support and supplement individual and community practice. We are all in this together and we must work together.

I

In the complicated way of life we have fashioned for ourselves, no problem exists in a vacuum. No undertaking, however important it may seem to any one of us or even to a great many of us, has any validity unless it be considered in terms of all the problems and undertakings of our varied world. Nor, indeed, can it be thoroughly understood or reasonably approached, save against that broad background.

Rehabilitation, as I shall try to point out, consists not simply of the correction of or compensation for disability, but rather the development of

a way of living, and this must inevitably be conditioned by the patterns obtaining in the community. Further, it will be rooted in the individual patient's background, hereditary and environmental, and no less in the background of those who try to help him. For the rehabilitative process, like any form of education, is involved as deeply in the motives and purposes of the teacher as of the learner.

It seems to me that the concept I offer you would have been valid in this country at any time in its history, because it is based upon convictions we share with our founding fathers. By the same token, it would seem strange and inappropriate in a totalitarian state, with its lesser concern for the individual and his prerogatives. I once had a visitor to the Paraplegia Service, a social worker from the other side of the Iron Curtain, who asked me what the daily program for the patients was. She was honestly uncomprehending when I told her that this would take some time to describe because there were as many programs as there were patients on the service. Such an arrangement, such meticulous seeking out of individual preferences and talents, would have been quite inconceivable in her country. She registered the usual objections, about the resulting lack of efficiency, that we expect from quarters where efficiency is esteemed more than human dignity. The incident shows what I mean by saying that the answer to any problem must be worked out in terms of the culture in which it is bred. The concept of rehabilitation I am describing has as its chief virtue that it tries to be consonant with the way of life that we, in this country, think is the only way worth living.

This article by Dr. Talbot was delivered as the Seventh Annual Smith Memorial Lecture at the Rockford Memorial Hospital, Rockford, Ill. Each year the Smith Charitable Trust brings to Rockford, and its medical community, an outstanding authority to conduct a one-day series of discussions and lectures on medical subjects of special interest.

Let us begin with a brief historical survey. Even after the practice of exposing deformed infants to the elements to die had been discontinued, and when a cripple no longer went in dread of being killed because he was useless or repulsive, there were yet many centuries during which the best he could anticipate was alms. In time, sanctioned and encouraged by the church, there arose the notion of caring for these people, as of the sick or the blind, and asylums in which they could be looked after were established. One such, founded in France in 1657 and later to become the famous Salpêtrière, was designed as a place in which the infirm could find suitable work, thus jumping the gun on the rest of mankind by a couple of centuries or so. In this, as in other triumphs of the human spirit, voices cried out in the wilderness before there were ears to hear.

Generally, however, the arrangements were merely such as to provide refuge and sustenance, with no idea of restoration to a place in the world and the joy of living. An expressed purpose, in fact, was to keep these unfortunates out of the way lest, by the ugliness of their deformities, they might offend the eyes and the delicate sensibilities of their normal fellows—this in an epoch that offered public executions as an agreeable form of outdoor entertainment. Another aim, perhaps more practical, was to keep the streets and highways clear of beggers.

Strictly speaking, rehabilitation as distinct from care and treatment is not a new idea, any more than was the theory of the roundness of the earth in 1492. But the wide range of its present application and the awakening of public interest are new enough so that the general concept has not yet acquired sharp definition. Its aims have been occasionally misunderstood and its methods occasionally misapplied. Its technics, borrowed from half a dozen arts and sciences—medicine and surgery, mechanics, psychology, sociology, pedagogy, and others—have yet to be co-ordinated to the fullest degree. There may be half a dozen people concerned with the rehabilitation of one man, each of whom quite sincerely thinks that his or her job is the essential one. The fact is that they are all essential, but no one of them is sufficient in itself.

The beginning of the modern trend can perhaps be traced back to early in the 19th century, by which time advances in orthopedic surgery had led to the establishment of the first institutions for the care and treatment of crippled children. As the number of such places increased, the scope of their activities expanded beyond the purely remedial, to include the training of those with residual deformities. Nothing significant was done for adults until about 60 years ago, when the conscience of the race perceived that this vast and tragic waste of human happiness was largely unnecessary. It has required the impact of two world wars to bring us up to date. For, during and after those wars, current methods of treatment returned to the stream of life mutilated, deformed, and variously disabled but for the most part physically healthy young men, in numbers not previously encountered. Never before had so many of the severely maimed survived in such generally good condition.

Physical handicaps are no longer the mark of the congenitally afflicted, or the infirm, or those who never knew life otherwise. They are borne now, in large part, by vigorous young men, who yesterday were among the best we had and who may still be so today. No less in peace than in war, many who would have died a few decades ago now survive, although not unscathed, crippling disease and the accidents of industry and transportation. All these

have made the doctrine of rehabilitation a matter of everyday necessity.

But I should like to urge upon you that this is not essentially an economic nor a political necessity, although these people are capable of making great contributions to our productiveness and to the vigor of our national life. It is, rather, a humane necessity, a process that helps us who administer it no less than those who are supposed to be the recipients of its benefits. It is a necessity because we realize at last, or should realize, that we are indeed our brothers' keepers, that, unless we offer to the handicapped the opportunity to live richly and fully, we shall not have lived richly and fully ourselves. I cannot escape the impression that this intensely personal feeling of responsibility—however it may be interpreted psychologically—is essential to the success of our enterprise. That is why I have already pointed out how deeply the process involves the motives of those who are engaged in the work.

II

Neither the disabled themselves, however, nor the public, nor even those who are doing the work of rehabilitation, seem to be altogether clear about what needs to be done nor what can be done, and a few serious fallacies have appeared. There is, for instance, a rather naive notion that practically all of these handicapped persons are potential world-beaters, eager only for an opportunity to display their great talents. This may have arisen in part from a wide, popular acceptance of the Adler theory of compensation, which can be supported by any number of individual instances but seems to fall short of universal applicability. The fact is, of course, that the proportion of world-beaters among the disabled is the same as in the rest of the population, which is to say, small. There are also, just as in the community at large, the lazy, the stupid, the inept, and the unsocial. A great many healthy people without physical handicaps are content merely to get along, and some drift off the pathways of industry and virtue.

Considered in terms of character, aptitude, and good citizenship, it is wrong to expect that the processes of rehabilitation can add much, if anything, to what was there before the disability was incurred. I hope that I may be forgiven for referring now and again to my own experience with the severely disabled. I do so because an undertaking so heavily dependent upon personal relationship can best be described in terms of persons. My work has been among patients with spinal cord injury or disease that has rendered them paraplegic or quadriplegic. What I have learned from them has come from having known them—almost a thousand in all—personally. It would be idle to deny the likelihood of significant personality changes in the presence of such drastic affliction. The extraordinary thing is how seldom they develop in a properly managed rehabilitative environment.

A few, very few, in fact, have failed utterly to make the necessary adjustments, but true psychopathic changes have been even fewer, and these in individuals in whom the tendency was almost certainly present before injury. A small number of my patients came to grief while engaging in criminal activity. All but one now tread the paths of righteousness, suggesting that a broken back is a forceful reminder that crime does not pay. (The exception was one of the psychopaths.) It might also be pointed out, with some truth, that being paralyzed closes the door to the more violent forms of crime. But we like to think that, in an atmosphere of mutual respect and consideration, men may realize, perhaps for the first time, that they get along best by being decent to each other. Improvement of his moral outlook, however, whether in these or in less dramatic instances, does no more than make the patient ready for rehabilitation. How far the process can go must still depend upon his own energy, ability, ambition, and other traits that are difficult if not impossible to fashion or modify.

To rehabilitate, from its original Latin meaning, is to restore, not to create. Having brought a patient to the best possible state of health and provided such mechanical substitutes for his lost functions as are available, we must offer him training, in such degree and kind as he is capable of accepting, calculated to help him to attain a status of dignity and self-sufficiency. In most cases it can be done, although it is seldom easy. Persons without physical handicaps also fail, all too often, to achieve this end. What must be remembered is that, by and large, the quality of the finished product will depend upon the quality of the raw material that went into it. In adults, the raw material of habits, tastes, and social attitudes has already been largely determined. The impact upon the personality of a crippling illness or injury may modify these traits for better or worse, but it does not make a new man. Bitterness, disappointment, frustration, and the boredom of long illness, not to mention physical discomfort, are major impediments to the development of a secure and contented individual, even without the prospect of permanent major disability.

Another important misconception arises out of our national faith in mechanical contrivances as the answers to all human problems. In this there is the danger that, lingering too long with the means, we may never reach the end. Many of our paraplegics, for instance, now own and operate motor cars, but we cannot, on this basis alone, call them rehabilitated. It makes good news pictures, but it is not enough. The public, of course, must be kept informed of this work, but there is no reason for supposing it unable to comprehend fundamentals: too often it gets only the window dressing. Sentimentalizing

and oversimplifying are currently popular but highly uncertain means of education.

The gadgets are helpful, often necessary, and they are sometimes (not always, alas) almost miraculously efficient. But in our admiration for the ingenuity they represent, let us not forget that they are only tools designed to help in doing a job. Their mastery does not bespeak its accomplishment. No patient can be blamed for grasping at every mechanical and prosthetic device available, nor for believing that, so equipped, he will have mastered all his problems. It is inexcusable, however, for those whose task it is to train him to permit him ever to forget that none is so well helped as those who help themselves. The great task is not to fashion a man, since that has already been done, but to bring him to an awareness of his own capacities and help him to fulfill himself.

III

Nothing better illustrates the intensely individualistic philosophy that still prevails in the United States, despite the cries of alarmists, than the resistance so frequently offered to rehabilitative efforts. This is seldom overt, being far more often manifested by apathy or lack of interest than by actual hostility. But it is clearly evident that our people, even when disabled, do not take kindly to having their lives worked out for them and the patterns of their existence planned, however benevolently.

During recent years I have had the privilege of visiting a number of rehabilitation centers in this country and abroad and of meeting many foreign colleagues. It has been heartening to observe that, on the highest level of endeavor, equally fine work is being done in many nations. There is, however, one difference worth reporting. Our American patients are less docile than their European counterparts about accepting jobs to which they are directed. This is not simply a manifestation of greater independence because of more generous pensions. It is the vigorous assertion of a man's prerogative to pick his own work, a prerogative which, being based upon specific ability, may not be categorically denied because of an irrelevant disability.

The problem, of course, is to have the ability emerge and develop, to make certain that the disability is reduced to irrelevance. The fundamental choice, however, must be the individual's own, not his doctor's nor his vocational counselor's, nor that of any of the host of people whose knowledge and skills qualify them to help but not to direct. No point needs more earnestly to be stressed than the need for being humble with those we wish to help. The absence of such humility is responsible for many of our failures. The very heart and essence of rehabilitation is self-sufficiency; it cannot be nurtured if it be denied at the outset. The greatest handicap of a disabled man is not the physical impairment itself so much as the fear that, because of it, he may be unable to follow his own bent and make his own choices. These, after all, are the prerogatives of that freedom to which we pay such constant lip service. The obligation that lies upon us is to show the patient that he can still make his own choices; it is not for us to make them for him.

This, of course, means that we must be prepared to teach, to encourage, to advise, but never to dictate. It means, too, that these men and women must be allowed to make their own mistakes, as we all have done. This may be very trying to the beholder, for it is not easy to be sympathetic with a course of action with which we disagree. Finally, it must be acknowledged that there are those who cannot be rehabilitated in the fullest sense. Some would not in any circumstances have become self-sufficient to the degree idealized in a free society, and for these we must be content with lesser achievements. It is no discredit to the whole work that not all of its results will be of equal excellence—not as long as we recognize clearly the difference between a finished job and a makeshift. It is helpful sometimes to be able to take refuge in a sense of humor. Heavyhandedness is very wearing, but every doctor knows how much comfort there may be in the appearance of casualness. Chesterton once wrote, "What can one be but frivolous about serious things? Without frivolity they are simply too tremendous." I am not quite prepared to recommend an attitude of frivolity, but a light touch causes no pain.

The economic factor has brought further confusion to the issue. While it is quite true that financial need is an important stimulus to a man's determination to rise above his disability, it is also true, now as ever, that man does not live by bread alone. The concept of self-sufficiency should not be limited to the economic sense, although that obviously must be included. There are times, in fact, when I wonder if we are not deceiving ourselves, mistaking a makeshift for a finished job, simply because a man is earning a living. I expressed this doubt some time ago in an article written for a journal in England and was interested in finding confirmation, in the next issue, in a letter from a paralyzed reader. He wrote in part: "To so many people a return to work approximating to the sort of work done prior to injury is synonymous with a return to the natural order of things. There is surely much more in life than just being cooped up in a factory or an office. Mental health is surely the primary condition, and I remain unconvinced that the only way to achieve that is by finding the patient a job. Satisfaction at being economically independent will not, I submit, compensate in the long run for an uncongenial job."

Motivation is a word glibly used—often too glibly—but it represents a complex of emotional and intellectual elements not easily identified, much less measured. Certainly, it is a reasonable assumption that most people work in order to earn money. As I write these words I am

reminded of Dr. Johnson's famous remark, "No man but a blockhead ever wrote except for money." But its full significance lies not in the implication of his disinclination to write for nothing, but rather of his choice of writing as a means of earning. Incidentally, he also said, "Men are seldom more innocently employed than when they are honestly making money."

Among my own patients and former patients, I have observed with interest that those who receive the most generous pensions, *i.e.,* those who became paralyzed while in service, are by no means the least assiduous in looking for, landing, and holding jobs or in engaging successfully in some form of self-employment. On the contrary, I believe that their record in this respect is rather better than that of their nonservice-connected comrades, whose pensions are adjusted to a mere subsistence level. Without speculating about the reasons for this, it is sufficient to suggest that actual need for money is not the only determinant for working, nor the amount earned the only criterion for the choice of work.

There is yet another sense in which, I believe, the economic aspect of rehabilitation has been falsely stressed. It has been considered necessary by some to "sell" the idea of rehabilitation by pointing out that it is cheaper for the community in the long run—cheaper, of course, in a pecuniary sense. The argument goes something like this: First, when these people have been brought to the point of earning their own livings, the public treasury, be it local, state, or national, is relieved of the drain of supporting them; second, they earn enough so that the taxes they pay more than balance the costs of their rehabilitation. Statistics are brought forward to prove this, as, indeed, they can be to prove anything. But suppose that the taxes paid by these people came to only one half of the sums expended in their behalf, or one quarter, or one tenth? Is there a point at which we might decide that the return did not justify the outlay and that our endeavors were, in consequence, unjustified? Is rehabilitation, indeed, a luxury to be indulged in only so long as it pays or breaks even, or an obligation of human decency to be met at whatever cost? Perhaps it is important to be assured that we can afford to carry on this work. Can we, believing what we do believe, afford to do otherwise?

The sort of argument I have just mentioned not only does grave injustice to the spirit of our people, it is a disservice to the cause of rehabilitation because it obscures its chief purposes. These, I insist, are fundamentally humane and not economic. If our efforts are to be inspired or even chiefly encouraged by the fact that they are going to save us money, then we come off second best by comparison with our ancestors who left their disabled on a mountain top. At least, they were not expected to return a profit. If the total amount of these taxes is cause for any satisfaction at all, it must come to those who pay them, from the knowledge that they are playing their part in the community.

No one but a fool denies the importance of earning a living. But simply to do so no more constitutes the complete rehabilitation of a disabled person than it would imply a complete and satisfying life for any other individual. Like the mechanical gadgets, it is a means and not an end. Any man, disabled or not, should do something with himself—something from the doing of which he can derive satisfaction and augment the sense of his worth as an individual, something from which, also, he can earn enough money to meet his particular needs. The true criterion of successful rehabilitation is not making a living but finding a satisfactory way of life.

IV

Educators say of a college that its function is not so much to give its students learning as to open their eyes to the truth and teach them how it may be sought. Similarly, the process of rehabilitation must open a man's eyes to what he wants to do with himself and help him to achieve his aims. It is a process that must begin at the very onset of the disability, for it demands, from the beginning, a reasonably satisfactory adjustment by the patient to the modifications of activity that have been imposed upon him. And it is a process that, in its most successful application, never ends. For rehabilitation is not a sort of degree or mark of distinction granted at the end of a course. It is, rather, a state of being to which one aspires, more or less approximated in various instances but never fully realized. It is a way of life.

Obviously, good health and its accompanying sense of physical well-being are highly desirable and may be set down as essential prerequisites. Despite serious gaps in our knowledge, more is possible now in this direction than ever before. With certain exceptions, most disabled persons may now expect lives of reasonable comfort and normal duration. In our enthusiasm over the fine results of our increasing medical and surgical skills, however, we forgot for a time that they were doing only half the job. They were making life longer and more comfortable, but not necessarily more worth living. It was, perhaps, natural that, when the medical profession began to assume in earnest its obligations in respect to rehabilitation, it should have emphasized those physical aspects for which the knowledge and technics were at hand.

As doctors, however, we have not yet brought the best of our philosophy to bear upon the essence of the problem. It has always been our noblest aim to treat man and not disease, however we may have strayed occasionally from this high purpose. Moreover, we are more and more being urged, and urging ourselves, to treat the whole man. When a patient presents himself, we do not stop at the chief complaint but work him up completely. We are not,

nor should we be, satisfied with any course of treatment that does not meet all the needs we have uncovered, regardless of whether he was himself aware of them in the beginning. Everyone has heard of the poor chap who comes in with some minor complaint or other, gets a wonderful work-up, and leaves the hospital, some weeks and an operation or two later, with his original complaint still untreated.

But when a disabled patient presents himself, we find it difficult to see beyond the disability itself, the missing or paralyzed limbs, the deformity, the loss of vision or hearing. Yet this is but the presenting facet at which the physician articulates with the patient. Behind it is an organism, a personality desperately needing to regain an image of itself in which will be preserved the precious core of individuality. We must study and understand the whole organism, the whole personality.

It is through no virtue of our own that a few have had this realization thrust upon us. The patient with a spinal cord injury presents, along with the obvious paralysis, such a variety of grave complications, autonomic, visceral, cutaneous, and the like, that his very survival requires the most painstaking observation and management. In fact, until the period of World War II, not enough such patients survived for more than a few months to attract general attention to their needs. Now there are probably more than 50,000 in this country, some say as many as 80,000, and those who are charged with their care must treat the whole man indeed or there will be none to rehabilitate. It has been an extraordinarily rewarding experience from which we have learned much that is applicable elsewhere in medicine and surgery. But, in particular, we have learned from these patients how to approach all the severely disabled, to recognize their particular needs, and to appreciate the almost unbelievable courage and resourcefulness with which they face the most formidable handicaps.

Because of the variety of patients' requirements, a high degree of specialization in treatment has been inevitable. The specialties are necessary, but someone must know the whole patient and know him well. Someone must draw the varied efforts together into a master plan, be aware of everything that is going on, direct the whole undertaking. Whether or not he contributes one of the special skills himself is less important than that he should understand the right time and place for all of them in each individual case. In short, the relationship of doctor to patient must be as intimate and direct, as charged with mutual confidence as has ever been idealized as a standard of practice. There is no more essential element than this in the concept I am trying to describe. Rehabilitation cannot be turned over altogether to specialists and special clinics. They have their part to play, but the key figure is still the patient's doctor. Whether he be a family doctor in private practice, or one of the team of specialists, or a full-time doctor in a large center is unimportant, but he must be there. Whatever its other implications, rehabilitation is a medical problem, and there is an essential quality in the physician-patient relationship that cannot be delegated.

For all this, we must recognize our limitations. In problems so highly individualized as those of rehabilitation, our insights will not always be sufficient. This is not a council of despair but a reminder to be humble. Plastic surgery, prosthetic appliances, and the fine accomplishments of physical medicine have all contributed immeasurably to equipping and preparing the disabled for useful and contented lives. But in themselves they may not get down to the essence of a man, and, if he has not within himself the desire for accomplishment, his response to all these efforts will be at best mechanical. For all our methods of medical and psychological investigation, we cannot reach into the secret places of the heart. We may stimulate and persuade, but the essential response must arise in the patient himself, and the sooner this is generally realized, the sooner it is acknowledged that most of the things we have been calling rehabilitation are not that but only a means to it, the sooner we shall have the results we want. Up to now, too much emphasis has lain on processes and technics, too little upon the individuals to whom they are applied.

It is not too difficult to provide a man with a pair of artificial legs and teach him to walk upon them. The next question is where will he walk? There is no determination in the legs themselves, but the manner and direction of that determination are none the less a part of rehabilitation, concededly the most difficult part. Paradoxically, it is just that individuality which we must so sedulously cultivate and encourage that places so many obstacles in the way of success. Unless it is encouraged, however, there can be no success worthy of the name. It is possible now for many, if not most, physically handicapped persons to get gainful employment without the onus of "made work." But in any given case we must ask as well, was this the work he chose for himself, or was it chosen for him? Was he discouraged from trying something else he preferred, or was encouragement lacking for a venture he wanted to try but feared to risk? Whatever aid he got, whatever training, whatever gadgets, was he permitted to make up his own mind, to choose his own way?

In promoting the cause of their rehabilitation, many have referred to the waste to society represented by disabled persons. The real waste, however, is not of so many mechanics or scholars or artists or scientists, but of the human beings who play these parts. The greatest danger a disabled man faces is not that he may lose his earning power but that he may, in boredom, apathy, and despair, lose the awareness of his own worth and dignity. The ma-

terial phases of the problem, although not fully mastered, are at least well in hand. The time is come when, if the work is to be fruitful, we must reach toward those intangible values that give life meaning and savor—toward a concept of rehabilitation that recognizes that man is, or is capable of becoming, a spiritual being. In this lies his capacity to overcome almost any physical handicap.

What, then, are we striving for? What is this concept all about? If all the things we generally call rehabilitation are simply a means to an end, what is the end itself? What is it that the disabled man must recapture in order that he may fashion a new and acceptable image of himself, overcome the handicap of his disability, and achieve self-sufficiency in so far as any one can in this crowded world? If you must have it in a few words—and I do owe you some effort to be concise—I should say that our man must find restored to him a sense of the security of his own individuality. If there is a keystone supporting the structure of our concept, this is it.

It may immediately be objected that this is inconsistent. For I have said that our undertaking must reflect the time we live in, and certainly one of the recurrent themes of life today is a lurking sense of insecurity. It is true that I cannot expect my patients to achieve a sense of security in a military or economic or political sense any firmer than that which supports most of us in these uncertain times. I may hope, as a physician, to be able to offer him security of his person to the extent of reasonable health and comfort. But the security of his individuality, drawn from an inward strength, will render him capable of standing up to any threat, at least as well as the rest of us do.

He cannot be spared, any more than we can spare our children, the trials all men must face. To each era of history comes its own problems, nurtured in the great intellectual currents that sweep across the earth from time to time. Today, we of the Western World are struggling to free ourselves from the trammels of materialism even as we must strive to make ourselves materially stronger. That is the desperate paradox we face and which we must resolve. We can do so only by reaching back and re-establishing the spiritual values that first gave us courage, confidence, and strength as a nation. This is the great problem of our generation. It is the chief problem of education: to learn the values that transcend material considerations and at the same time achieve mastery of the intricacies of our material culture. It is certainly the chief problem in rehabilitation, precisely because we have come to put so much faith in gadgets and medical skills, inadequate as they are, that there is a danger that our patients will depend upon them rather than simply use them for what they are worth.

It is, perhaps, a symbol of what I seek for the disabled, that in my general associations with most of my former patients, I am scarcely ever consciously aware of their disabilities. This is not merely a glossing over, or a matter of habit. Among those currently under treatment the same disabilities are a matter of constant preoccupation. The attitude, in fact, is not of my making but theirs. They bear their handicaps with a sort of grace that makes them unnoticeable. This also is a part of rehabilitation. Our concept is not made up entirely of intangibles. But, in the physical realm, we have reversed the old attitude; we concentrate on the abilities that remain until the disability seems, by comparison, less significant. I honestly think that in some instances it becomes, even for the patient himself, insignificant. For he has filled his life and his mind with things to do until he no longer misses the things he cannot do.

There is a theory that no severely disabled person, however intelligent and understanding, however clearly he acknowledges his predicament on the conscious level, ever actually accepts, in his subconscious, the permanence of his dysfunction. I have discussed this with many patients and perhaps half of them think it may be so; the other half doubt it. I have no firm opinion myself, and it seems unlikely that we shall ever have sufficiently extensive psychoanalytic studies to give us much sound evidence one way or the other. But this I do know: The great majority of these people, whether or not they have accepted the permanence of their disabilities, have made good preparation for a long siege. If some day the siege is lifted, fine. If not, they will not have wasted their time.

Whatever they can or cannot do physically, however great or small their handicaps, often in spite of discomfort and poor health, most of them are sure of themselves, satisfied that life is worth living, and doing their best to live it fully according to their several abilities. Most important of all, they are living their own lives, making their own choices, enjoying their rightful heritage.

So the goals we seek in the rehabilitation of the disabled are none other than those we should choose to see established for all, handicapped or not. We have come the full circle. I began by saying that the validity of our undertakings depends upon their fitting into the pattern of our culture. Now, as I close, I hope you will agree that the concept I have tried to define fairly reflects the meaning of our democratic ideal, our Christian ethic, our American tradition.

Nothing less will do.

The Psychology of Deafness

Techniques of Appraisal for Rehabilitation

by Edna Simon Levine, Ph.D.

Sensory Deprivation, Learning, and Adjustment

by Helmer R. Myklebust, Ed.D.

Two Books Reviewed by Lee Meyerson, Ph.D.

THE APPEARANCE of the first book-length treatments of the psychology of deafness will be noted by all professional workers concerned with problems of impaired hearing as an important milestone. The almost simultaneous appearance of two such books bearing identical main titles but differing radically in approach and content testifies to the increase in interest and activity in this field that has developed in the past quarter-century. Many psychologists will be surprised at the amount of data, the practical rules of thumb, and the intriguing ramifications to problems of general psychology that are presented in these volumes.

The authors are eminent and experienced investigators whose familiarity with their topic goes far beyond the confines of the laboratory and the clinic. They are known to numerous deaf persons and to workers for the deaf as beloved teachers, colleagues, and friends who have actively participated in the social and professional affairs of the deaf.

Deafness is a complex disorder, however, and the existence of multiple subgroups and subcultures among the deaf makes the separation of fact from fancy, or the probable from the plausible, even more difficult.

It is not surprising, therefore, that the approaches of the two authors to the problems of deafness are radically different. In part, this is a function of differing purposes, but it is surprising how frequently they come to markedly different interpretations from similar data. Both have occasion to quote Goodenough's comment about the Draw-a-Man Test that "the individual draws what he knows, not what he sees." The same phenomenon, of course, holds for the writers of books, and in complex fields we are often mistaken about what it is we think we know.

Dr. Levine's work, dedicated to the late Donald H. Dabelstein, is one of the fruits of the Office of Vocational Rehabilitation Research Fellowship Program and appears oriented to the present level of psy-

About the Authors . . .

Dr. Levine has been a consultant for the hearing impaired for the U.S. Office of Vocational Rehabilitation since 1953 and associate research scientist with the N.Y. State Psychiatric Institute since 1955. She has M.A. degrees from New York University and Columbia University and received her Ph.D. degree from the former in 1948. Dr. Levine is a fellow of the American Psychological Association and a diplomate in clinical psychology.

Dr. Myklebust is professor of language pathology in the School of Speech, professor of neurology and psychiatry in the School of Medicine, and director of the Institute of Language Disorders, Northwestern University. After earning M.A. degrees from Gallaudet College and Temple University, Dr. Myklebust received an Ed.D. degree from Rutgers University in 1945. He is a fellow of the American Psychological Association and a diplomate in clinical psychology.

About the Reviewer . . .

Dr. Meyerson is professor in the department of psychology, University of Houston, and in the department of psychiatry, Baylor College of Medicine, and is on leave to the division of rehabilitation medicine, Stanford University, for the current year. He received his M.A. degree from the University of California at Los Angeles and in 1950 his Ph.D. degree from Stanford. He is a past-president of Division 22, National Council on Psychological Aspects of Disability, of the American Psychological Association. Dr. Meyerson received the Research Award, Division of Rehabilitation and Counseling, from the National Personnel and Guidance Association in 1961.

chological practice in vocational rehabilitation agencies. She emphasizes, with numerous lists of psychological tests and specimen forms, the technics of appraisal that can be used in evaluating the individual deaf person for rehabilitation services, and in the process she communicates the many acute insights, the rules of thumb, and the tested practical knowledge that characterize the experienced clinician. Although diagnosis and treatment are mentioned, the bulk of the book, as its title implies, is devoted

The Psychology of Deafness; Techniques of Appraisal for Rehabilitation

By: **Edna Simon Levine**

1960. 383 p. illus. Columbia University Press, 2960 Broadway, New York 27, N.Y. $7.50.

to methods of appraising the here-and-now level of functioning of children and adults and organizing the data in such a way that a report can be communicated to another member of the rehabilitation team. The evaluation problems and the procedures for collecting psychological information in a rehabilitation setting by means of case history, interviewing, testing, and observation are discussed in some detail against an extensive background section describing the implications of hearing and impaired hearing. Throughout the book there is systematic consideration of the differing problems and procedures for obtaining information that is believed to be relevant in appraising deaf and hard-of-hearing children and adults.

The psychologist unfamiliar with deafness who evaluates clients for vocational rehabilitation agencies undoubtedly will find this discussion extremely helpful, although it is by no means a substitute for basic formal preparation in the administration and interpretation of psychological measures. Other professional persons who are familiar with deafness but not with psychology, and even the intelligent layman, will find these chapters clearly written and easy to read.

The volume concludes with a relatively brief, and relatively unhelpful, chapter that presents some unprecisely formulated research problems, a list of ingredients for collaborative team research, and advice on how to develop a research plan. This is followed by nine appendixes listing briefly some definitions and causes of deafness, auditory measurement technics, methods of communication, and lists of test publishers and of organizations for those with impaired hearing. A simplified glossary and selected bibliography are also included within the covers of this beautifully bound and printed volume.

As a scientific work, this book leaves something to be desired. It begins with a shocker on the first page of the Introduction by citing someone's opinion that there are 15 million "sufferers" from impaired hearing. Boyce Williams, who contributed the Foreword, cited correctly on the immediately preceding page of the text the figure that is congruent with present evidence, namely, 2,225,000 people. The error itself is not of critical significance, but it does illustrate the mixture of opinion and evidence that appears in this book; unfortunately, where opinion conflicts with evidence, the latter does not always win.

The entire first section of the book is written in a highly poetic, almost emotional style, in which the deaf person is portrayed as a "sufferer" who because of his impaired hearing lives a deprived and empty life in a soundless world. Dr. Levine, of course, is attempting to make the point that hearing is an extremely valuable tool, but she may have overstated the case.

More serious, perhaps, is the picture that is presented of psychological practice. The author is sensitive to the psychological problems of the deaf, but suggestions for solutions are generally lacking, beyond vague references to therapy or "authoritative" rehabilitation services, "compensating," or having a good premorbid personality. The psychologist appears to be an educated flunky whose task is to "understand" people and make reports to other workers. If this is actually the case, it is not clear that he is a needed person and the contrast with other members of the rehabilitation team is marked; a teacher teaches, a physical therapist strengthens muscles, a surgeon operates, the vocational people find jobs, while the psychologist "understands the problem."

The Psychology of Deafness; Sensory Deprivation, Learning, and Adjustment

By: **Helmer R. Myklebust**

1960. xii, 393 p. figs., tabs. Grune & Stratton, Inc., 381 Park Ave., New York 16, N.Y. $7.75.

Unlike the semipopular style of Dr. Levine's book and the uncertainty about the audience for which it is intended, Dr. Myklebust's work is basically an unusual textbook for students.

It is a scholarly book containing much original data on some basic psychological problems and showing evidence of much thought. It is a stimulating book abounding in many new and radical interpretations of the psychological effects of deafness, overflowing with the rich wisdom of the sensitive student of impaired hearing who has spent innumerable hours in observation, measurement, and experiment, and it is chock-full of numerous pointed and specific suggestions for further research. Dr. Myklebust is clearly a skilled and able teacher. He often leads into problems with fascinating bits of pertinent history or illuminating comment about problems in general psychology, physiology, neurology, and other fields that not

only stretch the boundaries of his discipline but also distinguish the thoughtful professor from the ordinary teacher. To be sure, the style and redundancy of material prepared for the ear and the ex-cathedra flavor of the lecture room also come through, but one is left with no doubts as to what Dr. Myklebust teaches his students.

It is only when one considers its contribution to knowledge that this becomes an exasperating book. In dealing directly with data, Dr. Myklebust is usually modest and tentative. Repeatedly he calls attention to the complexity of the problems and the presence of the many uncontrolled, unexplored, and unknown variables that can influence experimental results. With deplorable frequency, however, he then throws in an interpretation or a conclusion—often in italics—that flies far beyond the evidence and falls well within the uncultivated fields of pure, and not always reasonable, speculation.

The impression of special pleading is inescapable. This is not necessarily an undesirable way of inducing "complacency shock" among investigators working on the frontiers of knowledge and forcing them to consider possible explanations of behavior that presently are not in vogue. It can be highly misleading, however, to readers who are not aware of the startling assumptions that form the basis for some interpretations—assumptions for which no evidence is presented, assumptions for which contrary evidence is available but not discussed, and assumptions that many psychologists would find difficult to accept. The bland and easily palatable sequence of fact, assumption, and interpretation, as a philosopher once remarked in another context, is like taking a bath in water that heats up so imperceptibly that one does not know when to scream.

Dr. Myklebust's basic thesis is that impaired hearing is one kind of sensory deprivation that reduces the input of total experience and thereby creates an imbalance in all psychological processes. He attempts to demonstrate this by showing group differences between the scores obtained on certain psychological tests by "normals" and by groups of individuals who were found in schools, classes, and organizations for those with impaired hearing. After an excellent consideration of definitions, incidence, and causes of deafness, a brief review of the process of hearing, and a discussion of sensory deprivation and behavior, he proceeds to consider in systematic fashion the way in which deafness as a sensory deprivation alters behavior in mental development, personality development, motor functioning, and social maturity. The special problems of language—speech, speechreading, reading, and writing—and the effects of the presence of other handicaps, special abilities, and aptitudes are considered in separate sections. In each section, the author presents a compact history of the problem, some evaluation of the relevant experimental literature, and the data obtained by him and his students over the last 20 years. Given special prominence are data obtained in the last 5 years of a National Study of certain aspects of the psychology of deafness. Finally, almost every chapter concludes with a clear and forthright statement of the implications of the findings as Dr. Myklebust sees them.

This is an unusual textbook primarily because it combines traditional narrative with the first presentation of almost monographlike data from a massive research project. Nowhere in the book, however, is there an adequate statement of what the National Study was. Nowhere in the book is there a clear statement of the procedures detailing what was done, how it was done, how the raw data were treated, or even how much data are not reported here. These are serious omissions in scientific work, for other investigators are notoriously reluctant to accept processed data on faith. Practically, it means also that only Dr. Myklebust, and presumably his students, can teach from this book, for no one else has the information with which to answer the innumerable questions about the data that inevitably arise. Students and other investigators surely will read the book and profit greatly from the wealth of information and intriguing speculations it contains, but they are unlikely to accept the presented data.

For those who can accept the data, some serious questions still remain concerning the author's approach and reasoning. Some who are familiar with the recent evidence on sensory deprivation may easily reject the implications for deafness that Dr. Myklebust attaches to these phenomena. Others may have serious doubts that even "statistically significant" group differences form a sufficient basis for the conclusion that deafness is the "cause" of the differences. If deafness is a necessary and sufficient condition for the presence or absence of a behavior, there should be no exceptions. By analogy, for example, the author presents evidence showing that the hearing subjects were inferior to the deaf subjects on several measures. At no time, however, does he suggest that the hearing of the normal subjects was the "cause" of their inferior performance nor does he speculate about the imbalance in all psychological processes that may result from sensory bombardment.

Both of the books reviewed are essentially descriptions and value judgments of the present status of the deaf in our culture. If the books have a common limitation, it is that neither ever comes to grips with the problem of stating the conditions under which desirable behavior in the deaf can be fostered and undesirable behavior altered. It is by no means evident from either study that *what is* and *what must be* are identical. Nevertheless, both volumes, if they are read as points of view rather than statements of fact or summaries of present knowledge, will provide stimulating intellectual fare for students of deafness for many years to come.

Other Books Reviewed

903

Administration of Special Education Programs

By: **Leo E. Connor**

1961. 123 p. figs., tabs. Paperbound. *(TC ser. in special education)* Bureau of Publications, Teachers College, Columbia University, 525 W. 120th St., New York 27, N.Y. $1.75.

IN THIS HANDBOOK written for school administrators, educators, and parents of exceptional children, Dr. Connor examines administration of special education from the standpoint of general education and, specifically, its special functions and goals. Current status and resources of special education, administrative duties, and qualifications desirable in the administrator are discussed in the introductory chapter. Major problems in administration are identified and some of the solutions found in successful programs are noted. Dr. Connor has surveyed the literature carefully; his references are up to date and provide information on the special types of services available in various states, urban and rural areas. Guidelines are drawn for the establishment of special education programs and their administration under state and local auspices. Variations in size and type of special education programs are illustrated by descriptions of a large city system (Chicago); medium size city (Rochester, N.Y.); a county system (Dade County, Fla.); a suburban area (Leavittown, N.Y.); and a residential school (Lexington School for the Deaf, New York City).

Appendixes contain an outline of special education administration courses at Columbia University's Teachers College from 1906 through 1930 and a bibliography of selected special education periodicals.

904

Blindness; What It Is, What It Does, and How To Live with It

By: **Reverend Thomas J. Carroll**

1961. 382 p. charts. Little, Brown and Co., 34 Beacon St., Boston 6, Mass. $6.50.

AS FOUNDER AND DIRECTOR of St. Paul's Rehabilitation Center for the Blind, Boston, Father Carroll has gained nation-wide recognition for his work with the blind and in training others in his methods. His book is concerned with physical, psychological, social, and economic losses that occur when a sighted adult becomes blind: these losses he analyzes exhaustively before discussing the means of restoring or substituting for what has been lost. Total rehabilitation demands of the blind person courage and strenuous effort to make a successful adaptation. The remainder of the book covers problems of families of the blind, public education, the special problems of blind persons of various age groups or with multiple handicaps, and the organization of work for the blind. In the appendix "The Religious Care of the Blind" is discussed briefly. The book should be required reading for professional personnel and laymen alike who wish to understand the many implications of blindness so that they may help in constructive ways. The blind themselves should find here answers to many of their problems; Father Carroll challenges them to try to live successfully as independent and socially responsible persons.

905

The Church and the Exceptional Person

By: **Charles E. Palmer,** Ph.D.

1961. 174 p. illus. Paperbound. Published for The Cooperative Publication Association by Abingdon Press, 201 Eighth Ave. S., Nashville 2, Tenn. $1.75.

MINISTERS, TEACHERS, AND LAY MEMBERS of the church should find this small book especially helpful in understanding and serving people with exceptional problems caused by physical or mental handicaps. Writing in nontechnical language and an easy-to-read style, Dr. Palmer has managed to convey a volume of information in condensed form. He traces briefly changing attitudes toward exceptional persons, suggests responsibilities the church should recognize, gives general "pointers" to be remembered in work with the exceptional, and defines the characteristics and problems of persons with a wide variety of handicapping conditions. Specific suggestions on ways of helping these people and on planning and organizing services of the church in their behalf are included. Other chapters list the necessary qualifications and preparation for teachers of the exceptional and the responsiblities of Christian citizens in community-sponsored services. Also includes a brief bibliography of literature on exceptionality and a list of agencies that provide assistance to the exceptional and their families.

In addition to more than 25 years' experience in the field of special education, Dr. Palmer has also been a student of theology. He is currently speech and hearing consultant in the department of special education, Northwestern State College, Natchitoches, La., and is author of the recent book *Speech and Hearing Problems; a Guide for Parents and Teachers* (see *Rehab. Lit.*, Sept., 1961, #674).

906

Counseling in the Rehabilitation Process

Edited by: **Abraham Jacobs,** Ph.D.; **Jean Pierre Jordaan,** Ph.D.; and **Salvatore C. DiMichael,** Ph.D.

1961. 128 p. Paperbound. Teachers College, Columbia University, Bureau of Publications, 525 W. 120th St., New York 27, N.Y. $2.50.

THIS MANUAL, presenting major addresses, summaries of question and answer sessions, and a concluding statement by Dr. Jordaan at a training institute for experienced rehabilitation counselors, is intended for use in continued inservice training of state vocational rehabilitation agency staffs. Counseling technics were examined critically in relation to rehabilitation philosophy.

Contents: Foreword, Mary E. Switzer.—Current approaches to counseling, Paul E. Eiserer.—Client-counselor relationships, Leonard Diller.—Understanding and counseling the resistant client, Henry Kavkewitz.—The appraisal process in counseling, Donald E. Super.—Effecting changes in client attitude, C. Gilbert Wrenn.—Counseling and psychotherapy as an instance of coalition, Harold B. Pepinsky.—Decision-making in the counseling process, Albert S. Thompson.—Helping the client accept his disability, H. Robert Blank.—Multiple relationships in counseling, Elinor Stevens.—Concluding remarks, Jean Pierre Jordaan.

907

The Effects of Listening Training on the Auditory Thresholds of Mentally Retarded Children

By: **Bernard B. Schlanger,** Ph.D.

1961. 116 p. figs., tabs. Paperbound. *(U.S. Off. of Education Cooperative Research Project no. 973 (8936))* Dr. Bernard B. Schlanger, Speech and Hearing Clinic, West Virginia University, Morgantown, W. Va.

MAIN OBJECTIVES of the investigation were to compare various types of current auditory assessment technics and determine more efficient methods of evaluating hearing in the mentally retarded. A selected battery of 6 hearing tests, each requiring a different response, was administered to 199 children (187 from the West Virginia Training School, 32 from special education classes of Monongalia County schools). An auditory training program consisting of 30 progressively structured lessons was established to determine what effect such a program would have on auditory thresholds. Repeated testing was found to have lowered the incidence rate of hearing loss considerably. Findings indicated that the Speech Reception Threshold Test is possibly the best choice for evaluating hearing in retarded children; GSR audiometry is recommended only as a last resort. Dr. Schlanger reviews the literature concerning investigations of hearing testing of retarded children as well as references relating to auditory training programs. Procedures and data from the study are reported in detail. In addition to a bibliography of 92 references, appendixes contain a description of Speech Reception Threshold Test procedures; objectives, methods, and materials used in the listening program; and data on average audiometric thresholds of the study subjects at spaced intervals of testing.

908

Experiments in Survival

Compiled and edited by: **Edith Henrich** (Commentary by **Leonard Kriegel)**

1961. 199 p. Association for the Aid of Crippled Children, 345 E. 46th St., New York 17, N.Y. $3.50.

NONE OF THE 33 physically handicapped persons whose personal accounts of learning to live with a handicap appear here was chosen because he or she was "outstanding" in any overt way. It was the hope of those who planned the book that these stories by "average" men and women, presenting their experiences and attitudes, might offer a new perspective on the individual with a handicap, leading to greater public understanding and beneficial results for others who are handicapped. Disabilities of the various writers were the result of poliomyelitis, multiple sclerosis, war injuries (blindness, amputation, paralysis), paraplegia, loss of vision at birth or in later years, cerebral palsy, osteogenesis imperfecta, and loss of hearing. Mr. Kriegel's story and his postscript to the book appeared in the October, 1961, issue of *Rehab. Lit.* (p. 294-301).

909

Final Report of a Demonstration Project . . . in Pulaski County, Arkansas, May 1, 1957-September 30, 1961: "To Establish an Orderly, Systematic Method of Processing Vocational Rehabilitation Cases in Pulaski County . . ."

By: **Arkansas Rehabilitation Service** (W. R. Ooley, Project Director)

1961. vii, 109 p. tabs. Mimeo. Paperbound. *(Office of Vocational Rehabilitation Grant no. 147)* Issued by The Arkansas Rehabilitation Service, Arkansas State Board for Vocational Education, Little Rock, Ark.

USING A GROUP APPROACH similar to that employed in hospitals and rehabilitation centers, the demonstration project provided co-ordinated services through a staff consisting of 2 vocational rehabiliation counselors, a psychologist, a social worker, an intake counselor aide, a physical restoration services counselor aide, a training and placement counselor aide, and 4 secretarial workers. The project director served also as supervisor of the agency, responsible for day-to-day supervision of operations. This report discusses in detail the methodology of the project, some problems in establishing detailed procedures of operation, and data on results of the proj-

ect as compared with previous years' performance. One of the major advantages of the 4-year experiment appeared to be the ability of the group to help more severely handicapped persons achieve satisfactory vocational, as well as total, rehabilitation. The provision of better, more comprehensive, and more nearly complete services to most of the clients served was also an achievement. Extensive data are included on clients served, costs involved, and results of a follow-up study after the first year of project operation. Recommendations are made for future operation of vocational rehabilitation agency programs in Arkansas and application of the findings to programs in other states. Papers by the project psychologist, social worker, a counselor, and a counselor aide on "The Project As I See It" are given in conclusion.

910

Jahrbuch der Fürsorge für Körperbehinderte, 1961.

By: **Deutschen Vereiningung zur Forderung der Körperbehindertenfürsorge** (German Association for Crippled Care)

1961. 170 p. Paperbound. Published by Georg Thieme Verlag, Herdweg 63, Stuttgart-N, Germany, and distributed in the U.S. and Canada by International Medical Book Corporation, New York 16, N.Y. $1.50.

THE ANNUAL REPORT for 1961 of the German Association for Crippled Care reviews progress for the year and includes papers from the annual meeting and various conferences. Sixty years' work of the Association of German Protestant Institutions for the Physically Handicapped is summarized; the role of religious educational institutions in promoting welfare of the physically handicapped was considered by participants in a meeting of Catholic Institutions for the Crippled. Individual papers presented at the various meetings discussed: attitudes of the physically handicapped toward their future; problems and ways of providing assistance; justification of employment of the physically handicapped; principles of rehabilitation; speech and hearing; the founding of the Association for Welfare of Spastic Children and Youth; physical therapy for the cerebral palsied child; care and management of the severely handicapped; and sheltered workshops. Also contains programs of conferences scheduled for the early months of 1961 and a bibliography of recent German publications on rehabilitation.

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Physical Therapy, Functional Reeducation: Proceedings of the Third International Congress of the World Confederation for Physical Therapy, Paris, September 6-12, 1959

By: **World Confederation for Physical Therapy**

1961. 383 p. Paperbound. World Confederation for Physical Therapy, Tavistock House (S.), Tavistock Square, London, W.C. 1, England.

PAPERS PRESENTED at the 1959 International Congress cover a wide variety of topics—the physical therapy treatment of a number of medical conditions, physical training as therapy, the human, economic, and social role of functional rehabilitation, the physical therapist in a rehabilitation program, geriatric rehabilitation, and physical therapy in psychiatric hospitals, to mention a few. Some of the articles have been reprinted in various professional journals (see *Rehab. Lit.*, Feb., 1960, #96; May, 1960, #366 and 368; Aug., 1960, #606; and Sept., 1960, #688). Several articles specifically concerned with the treatment of cerebral palsy (by Dr. Guy Tardieu and his coworkers, Michel Le Métayer, and Mrs. Patricia Beaman) will be found on p. 243, p. 210, and p. 251, respectively.

The Proceedings, in either English or French, may be obtained from: Camille Marcellon, 73 Rue des Vignes, Paris 16, France, at 35 N.F. a copy (including postage).

912

Strokes; How They Occur and What Can Be Done About Them

By: **Irvine H. Page**, M.D., and **Clark H. Millikan**, M.D., **Irving S. Wright**, M.D.; **Edward Weiss**, M.D.; **E. Stanley Crawford**, M.D.; **Michael E. De Bakey**, M.D.; **Howard A. Rusk**, M.D.

1961. 226 p. figs. E. P. Dutton & Co., 300 Park Ave. S., New York 10, N.Y. $4.50.

THERE IS NO NEED for the average person to be misinformed on the subject of strokes when such a scientifically accurate, up-to-date book, written by 7 leading medical authorities, is available. Each is a specialist in the subject he covers and understands the need for practical suggestions on care, treatment, and rehabilitation measures. Dr. Page discusses the extent of the problem from the standpoint of the family, the patient, the doctor and personnel of ancillary professions, and the general public. He also explains the actual mechanism of strokes and describes (nontechnically) the complexity of the brain and nervous system, emphasizing the necessity of the patient's efforts if rehabilitation is to be effective. Dr. Millikan covers diagnosis and its problems; Dr. Wright, treatment methods. The late Dr. Weiss discusses the role of emotions in the course of the illness and how the family should deal with emotional problems as they arise. Drs. Crawford and De Bakey describe significant advances in treatment due to modern vascular surgery; technics of surgery are explained. And last, Dr. Rusk, from his extensive experience at the Institute of Physical Medicine and Rehabiliation, tells of the rehabilitation center's team approach to treatment and what can be done in the home. This chapter includes specific instructions on proper

positioning, exercises, and ambulation, with a discussion of speech rehabilitation and self-help aids.

913

Service for Children with Emotional Disturbances; A Guide for Public Health Personnel

Prepared by: **Committee on Child Health, American Public Health Association**

1961. 120 p. Paperbound. American Public Health Association, 1790 Broadway, New York 19, N.Y. $1.50.

THE FORMAT of the ninth, and latest, guide in the series published by the American Public Health Association is similar to the earlier ones; all are directed chiefly to professional persons concerned with the extent and operation of community services to children with various handicaps. A summary of current knowledge and points of view about children handicapped by emotional problems and ways of providing services to help them is included. Although consideration is given to normal growth and development in children, the range of normal behavior, and mental retardation as one of the many factors in the etiology of emotional disorders, the guide is *not* a manual for the care of healthy children with minor behavior upsets or a guide to services for the mentally retarded. Discussed are the causes and prevention of emotional disorders in children, case finding, diagnosis and treatment, special services and facilities, professional personnel involved, organization of community resources, and trends in research. Appendixes contain a list of national voluntary and official agencies with special interests in emotional problems of children, official agencies designated as state mental health authorities, and a glossary of terms found in the literature on emotional disorders. For information on titles of the series's guides published to date, write the Association. Complete sets of the guides are offered at a special price.

914

Teaching the Retarded Child To Talk; A Guide for Parents and Teachers

By: **Julia S. Molloy, M.A.**

1961. 125 p. John Day Co., 210 Madison Ave., New York 16, N.Y. $3.50.

NINE OF MRS. MOLLOY'S more than 30 years' work with abnormal children were spent as language pathologist at the Dr. Julian D. Levinson Research Foundation, Cook County Hospital, Chicago. Presently director of a school for retarded children, she recognizes the importance of close co-operation between family and teacher. This book should be of interest to both; it was written, however, mainly for parents and in language they can understand. Mrs. Molloy tells why some children fail to learn to talk, explains the normal processes of learning to speak, and discusses basic steps in developing speech in retarded children; a chapter on special technics for teaching the mongoloid child is included. By following the specific and practical suggestions and utilizing the sequential curriculum plan and materials suggested for young severely retarded children, parents should be able to help their children achieve many, if not all, of the listed goals for useful speech.

915

Teaching Arithmetic to Deaf Children

By: **Veronica O'Neill**

1961. 143 p. figs. *(Lexington School for the Deaf Education Ser., Book III)* The Volta Bureau, 1537 35th St., N.W., Washington 7, D.C. $3.20.

EDUCATIONAL PHILOSOPHY as applied to the teaching of arithmetic, from the nursery and kindergarten program through high school, at Lexington School for the Deaf is discussed in detail by the author, a teacher at the School for nearly 20 years. Much practical information on activities, technics, and devices found effective in developing the deaf child's mental image of numbers and numerical quantities is included; extensive lists of texts and materials such as games, charts, records, and other adjuncts to teaching are given. Ways of correlating arithmetic instruction in the teaching of other subject contents are emphasized. The developmental skills and concepts for grade levels are those prescribed by the New York State Education Department for all public school pupils. The Lexington School for the Deaf Education Series of monographs is published by the Alexander Graham Bell Association for the Deaf, in response to the many requests for courses of study covering the program offered at the School; each unit deals with a particular subject area. Books I and II (see *Rehab. Lit.*, Oct., 1960, #721, and Nov., 1960, #789) contained an annotated list of filmstrips for use with the deaf and a discussion of school library services.

916

Techniques and Procedures of Rehabilitating Severely Disabled People in Small Business Enterprise Objectives; Final Project Report

By: **Alabama School of Trades** (Project Director, E. L. Darden; Project Co-ordinator-Principal Investigator, Shilton L. Gilliland)

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(Continued on page 374)

Digests of the Month

Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.

917

Psychodrama in the Area of Vocational Rehabilitation: Discussion and Demonstrations

By: **Barbara Seabourne**, Psychodramatist, St. Louis State Hospital

In: *Problems Unique to the Rehabilitation of the Psychiatric Patient: Proceedings, January 26, 27, 1961,* sponsored by St. Louis State Hospital, Missouri Division of Mental Diseases, and Missouri Division of Vocational Rehabilitation, p. 83-88. Editorial Committee: Louis H. Kohler, M.D., and Donald Baird, Stanley J. Bryer, and Brockman Schumacher, counseling psychologists. 1961. Issued by St. Louis State Hospital, 5400 Arsenal St., St. Louis 9, Mo. 118 p. Mimeo. Spiral-bound.

This session focused on the use of psychodrama in rehabilitation problems, opening with a summary of its use in the St. Louis State Hospital. (The St. Louis State Hospital has recently been accredited by the Society of Group Psychotherapy and Psychodrama as a Training Institute for Group Therapists and Psychodramatists.) It was explained that psychodrama is an action approach to group work and can be used in individual counseling.

THE SET OF TECHNICS, psychodrama, has a theoretical framework within which methods adapt to any preferred orientation or type treatment. To the emotional involvement of verbal therapy is added the dimension of action. The patient is not asked how he will handle a situation—he is in it. When you play the part of an employer interviewing him and confront him with "What kind of hospital were you in?" or "Where have you been the last 2 years?" the patient may find the way he plans to present, or avoid admitting, his hospitalization not the best way to impress the employer. A patient who has just told his counselor he will not reveal his illness in an interview will sometimes to his surprise blurt out and stress his illness in the psychodrama.

Best defined by experience and example, psychodrama is a means of confronting the patient with the situation, highlighting, if desired, its emotional features. The problem is worked on at a level difficult to reach or more slowly reached by verbal technics alone.

Psychodrama is used in the St. Louis State Hospital for intensive psychotherapy groups, both inpatient and outpatient; with adolescents to help clarify feelings, problem areas, and role expectations and difficulties encountered; and with ex-patients having difficulty adjusting in the community.

On ward communication problems, psychodrama has been used with groups including patients, ward personnel, physicians, social workers, clinical and counseling psychologists, and others involved in patient care and treatment. Such milieu therapy stimulates healthier attitudes and means of communication, creating better ward atmosphere.

Orientation, supervision, and communication among staff members are areas where psychodrama is used with training groups. The Psychodrama Unit conducts such groups with counseling psychologists, medical students, nurses, chaplain interns, outside volunteers, and junior and senior professional staff members. Psychodrama is used to increase communication among disciplines and among high level staff members; it is utilized for supervision of psychotherapy, vocational counseling, and pastoral counseling. At present a psychodramatist is consultant to members of the Vocational Rehabilitation Section, individually and in a group. Counseling psychologists use psychodrama in many areas.

A patient before seeking work will practice job interviewing, separation from hospital, and community situations he may face. Role-training groups clarify and prepare for situations and allow the patient to practice with minimum anxiety. He absorbs a clear picture of himself, his assets, and liabilities. In such groups *problem presentation, role reversals,* and *mirroring* are commonly used technics. In the first-named, the patient plays himself in a situation with other patients and staff playing community or family figures or hospital personnel. In role reversal, he portrays someone else and another person takes his role. He sees himself from another viewpoint, perhaps an employer's. He may say, "I wouldn't hire anyone who acted that scared." The counselor and other patients then may help him practice to act less afraid. He gains awareness of how an employer evaluates applicants—by their volume of voice, posture, mannerisms, verbal responses. Mirroring achieves similar experiences: Another patient or the counselor presents as clearly as possible the behavior of the patient, while the patient watches his "mirror" and sees hindering factors more clearly. A change in self-attitude can result.

Prevocational counseling with groups of patients not yet ready to leave focus on such areas as fear of leaving the hospital, what kinds of jobs to seek, and fears of such things as using the telephone or getting on a bus.

Sometimes problems met in hospital industry are covered. Goals are the same as those of the role-training group (community-vocational adjustment, with some focus on vocational aspects), but more time is spent on self-attitudes and motivation problems. If the counselor wishes, emotional problems are dealt with on the level characteristic of psychotherapy groups. These meetings are often focused on interpersonal relations—family, educational, hospital, and work relationships. As well as problem presentation, role reversals, and mirroring, we use *doubling,* in which someone else sits beside the patient and tries to express his unrevealed thoughts and feelings. This helps the patient express himself more openly and directly. The counselor may then work through his feelings. In *behind-the-back,* the patient symbolically leaves the room by turning his chair; the group discusses his strengths and weaknesses and their feelings about him. The technics are followed by group discussion.

Often *future projection* is used, with patients pretending it is some time in the future and discussing where they are and how they are progressing. Expectation, motivation, and realistic or unrealistic aspirations are thus clarified. Valuable material is often yielded for future exploration.

Participants of the Institute demonstration focused on warming up to a more vibrant and meaningful interaction and breaking down professional and social inhibitions. Circular seating and use of doubles encouraged them to discuss their counseling roles in a less stilted and academic fashion and to be freer about their feelings as vocational rehabilitation counselors. At first the doubles spoke for the group as a whole, but as members began to speak more, doubles were assigned to persons who preferred a highly intellectual and nonpersonal level. Activity increased and content became more personalized and informal. With more emotional involvement and participation, members focused on experiences, feelings of success, and inadequacies. At the closing discussion many stated that future Institutes should use the psychodramatic warm-up at the beginning instead of the end of the Institute.

Later sessions were reported more communicative and livelier. The circle was chosen for future use rather than more formal speaker-audience seating.

918

Project "Gemstones," One of the Rehabilitation Foundation's Projects for the Orthopedically Disabled in Ontario

By: **Madeleine Fanais**

In: *Canad. J. Occupational Ther.* Sept., 1961. 28:3:89, 91-94.

OF OUR PATIENTS NEEDING WORK the most difficult to place are those who: 1) have severe disability with a history of purely manual labor; 2) have less than Grade 8 education (for reasons other than native low IQ); 3) live in an area having heavy industry but no light industry; 4) live in a rural farming area, with no industry near; 5) are unable to relocate because of physical and economic dependence on relatives.

There is no *one* solution to this problem. This article deals with *one* of the projects launched by the March of Dimes as being at least a partial answer. "Gemstones" is the name given by the Rehabilitation Foundation to the lapidary workshop project, which was put into action after careful evaluation of its feasibility. We found products would be marketable if prices were competitive, for there is a growing interest in rocks and gems in North America, with a do-it-yourself trend going, which always stimulates sales also in a finished product. Emphasis would be put on the Canadian souvenir trade, as articles of good taste are in demand. Semiprecious and ornamental stone abounds in Canada, sometimes unique to a vicinity. The findings for jewellery unfortunately can be had more cheaply from the United States than natively.

Power tools such as a diamond saw, a slab saw, and grinding and polishing wheels can be obtained at cost for from under $70 for a table model unit with interchangeable discs to perhaps $1,000 for a complete set of separate machines for a 2 or 3-man workshop. A ground-floor workshop with running water and benches at wheelchair height with good overhead lighting and heavy-duty wiring for motors are main requirements—for basic stock, a variety of rock, costing from 35¢ to $1.50 a pound, a special epoxy resin adhesive, and an assortment of findings.

The entire operation in lapidary work can be done from a wheel chair and is suited for either sex and any age. There is little danger of accidents; diamond saws cut rock but not fingers. I append a list of books that describe the production process. Two hands are needed, but high motivation and ingenuity are amazing substitutes: A rheumatoid arthritic with typical bilateral severe hand deformity became skilled and claims his hands have been strengthened. The greater the skill the better the work. A minimal talent can get by, especially with baroque jewellery, made with rock shaped and polished by being tumbled in a rotating drum of grit and water solution, gradually progressing to finer grit, and finally to polish and water, the stones then being cemented to findings.

Lapidary is a highly respected art, and new-found prestige and admiration for the product does wonders for the morale of a disabled person.

Our pilot project was begun with a few disabled people in a rented small ground-floor workshop in Ottawa with the minimum equipment installed. The area case-worker was an occupational therapist and a volunteer instructor was found—an enthusiastic home basement lapidarist. He gave valuable instruction, wired machinery, and wrote to rock and mineral clubs for donated material.

From the start we could not keep up with the demand! The pilot project got off the ground in January, 1959, and soon we were bursting at the seams—in June we moved to larger premises and installed more equipment. We then tried to get enough stock together to meet the Christmas trade and began 2 months of training other handicapped people with the aid of two project veterans. These months were hectic but stimulating, with the new trainees flying in to face an unknown town and unfamiliar motel, order meals and taxis, and put in a full day's work —more than they dreamed they could do. Without ability to do this, training is useless. Reluctantly we had tried out one or two with neurological cases—partial hemiplegia and upper motor neurone damage. Their enthusiasm and eagerness far outstripped their performance, and we were sorely tried to put them down gently. However, colour-blindness in a paraplegic proved to be his greater disability.

The next stage might be called the consolidation of our position. Before training new people, the old ones must be established and markets built up. In some cases one-man home workshops were set up and stocked, in others the nucleus of a small centre for several people had to be discussed with local committees.

Our first opportunity to show our goods was at the February (1960) Gift Show at Toronto, where we had a stand given us for 4 days. The whole future of "Gemstones" depended on public and business reaction and orders taken at this, our first shop window in open competition with other wholesale jewellery and gift suppliers. Orders kept us busy right up to the Fall Show in September, many customers reordering by wire.

At the following Gift Show we hoped to display products of the new workshops. The Ottawa centre closed as a training workshop, the machinery was distributed around, and the veteran lapidarists who had helped us the first year were given means and equipment to start businesses in Ottawa. There was a hunt for rented space, while orders (coming from Muskoka and Gaspé, P.Q., Victoria, B.C., and the fashionable Bloor/Bay area of Toronto) were stalled.

The Ottawa shop now has nine tumblers, each holding 8 to 10 lbs. of assorted rocks, filled and rotating day and night. Also operating are a workshop at Lakehead and one-man workshops in Cornwall, Ont., and in Toronto.

It is still too early to say the project is an unmitigated success—what small business makes a fortune in the first or second year of operation! We have learned much about selecting candidates—ability is the important criterion. Rather more skill is required than was first thought, or some good substitute such as common sense and intelligence. Plans now are to have an experienced person co-ordinate the various workshops and provide constructive production ideas and improvements. New and promising candidates are trained at the nearest workshop in a short apprentice period.

Bibliography*

Small Business Manual. Ottawa, Can.: The Queen's Printer.

The Exciting World of Rocks and Gems, by Elsie Lee. Trend Book 187. 75¢.

The Art of Gem Cutting, by H. C. Dake. Spokane, Wash.: J. D. Simpson & Co. 1956. $2.00.

Gem Tumbling and Baroque Jewelry Making: A Guide for Amateur Tumblers, by Arthur Earl Victor and Lila Mae Victor. Spokane, Wash.: J. D. Simpson & Co. 1957. $2.00.

Gemstones of North America, by John Sinkankas. Princeton, N. J.: D. Van Nostrand Co., Inc. 1959. $15.00.

Gemcraft: How To Cut and Polish Gemstones, by Lelande Quick and Hugh Leiper. Philadelphia, Pa.: Chilton Co. 1959. $7.50.

The Canadian Journal of Occupational Therapy is published quarterly by the Canadian Association of Occupational Therapy, 331 Bloor St. W., Toronto 5, Ont.; subscription rate is $2.00 yearly.

*As revised by *Rehabilitation Literature.*

(Continued from page 371)

A detailed analysis of case records of 150 handicapped persons operating small businesses in northern Alabama, each aided in setting up a business by the State Vocational Rehabilitation Service, indicated the value of preparatory training and supervision following opening of the business. Of the 110 persons comprising a control group, only about 10% received preparatory training; 43% of the group later failed in business as compared to 22% of the 40 persons making up the demonstration group who were screened and trained by the School of Trades. An attempt was made to determine what characteristics of clients might indicate the reasonably good self-employment risk; the factors involved in selection of the appropriate business for the individual; and the training procedures that were profitable before placement. The report contains a number of forms used in recording data for the study; the detailed descriptions of methods and experiences during the 3-year project should be of interest to rehabilitation counselors and supervisors involved in vocational placement of the handicapped. Businesses operated represented skilled trades service, retail sales outlets, and agricultural enterprises. Disabilities covered a wide range but it was the opinion of the principal investigator that only a very insignificant number of clients failed because of their physical incapacity to perform job tasks satisfactorily.

This abstracting section, together with other numbered references indexed in this issue. serves as a supplement to the reference book Rehabilitation Literature 1950-1955, *compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.*

AMERICAN ASSOCIATION FOR REHABILITATION THERAPY

919. Gable, Conrad *(Bronx VA Hosp., 130 W. Kingsbridge Rd., New York 68, N.Y.)*

A.A.R.T. relationship with A.M.A., by Conrad Gable and Henry Meyers. *Am. Arch. Rehab. Ther.* Sept., 1961. 9:3:4-15.

After initial organization and consolidation in 1950, the American Association for Rehabilitation Therapy, as a paramedical society, sought to establish relationships with the American Congress of Physical Medicine and Rehabilitation and the American Medical Association. This article tells in some detail the actions taken on the part of the three organizations considering such relationships and includes much data on activities and membership of the A.A.R.T. The final report of the Committee to Study Relationships of Medicine with Allied Health Professions and Services, A.M.A., was adopted by the A.M.A. House of Delegates in 1960; its significant recommendations should be studied since they describe responsibilities for the physician and therapist.

AMPUTATION—EQUIPMENT

920. Brodsky, Roberta *(Child Prosthetic Studies, Research Div., Coll. of Engineering, New York Univ., New York, N.Y.)*

The use of the SACH foot with children, by Roberta Brodsky and Hector W. Kay. *Orthopedic & Prosthetic Appliance J.* Sept., 1961. 15:3:261-264.

Experiences and reactions of 129 juvenile amputees fitted with 158 prostheses with SACH feet are reviewed from data obtained from 12 specialized child amputee clinics co-operating with New York University's Child Prosthetic Studies. Data include information on medical, fitting, checkout, and training aspects of the prosthetic treatment program. Of the 158 SACH feet examined, 143 were reported as being satisfactory in every respect. SACH foot fittings for child amputees do not appear to pose any special gait or fitting problems. Replacement of the foot to match changes in shoe size is desirable, however.

921. Tosberg, William A. *(Institute of Physical Medicine and Rehabilitation, 400 E. 34th St., New York 16, N.Y.)*

The adjustable leg and its uses. *Prostheses, Braces, Technical Aids.* 1961. 9:4-8.

A discussion of the drawbacks in earlier systems used to align lower extremity prostheses, with a description of the adjustable leg designed by the University of California. Consisting of several parts that are adjustable against each other, it allows for changing of the position of the knee and foot in relation to the socket, to insure the smoothest and most effortless gait of which the patient is capable. This alignment device allows the prosthetist to observe the relationship of the component parts in the swing phase as well as in the several positions of the stance phase and has the added advantage of correcting lateral and medial "whip."

AMPUTATION—MEDICAL TREATMENT

922. Dederich, R. *(St. Peter's Hosp., Bonn, Ger.)*

Complications in the amputation stump and their surgical treatment. *Prostheses, Braces, Technical Aids.* 1961. 9:9-13.

Reprinted from: *Monatschrift für Unfalheilkunde.* 1960. 63:3:101-108.

Pain and circulatory disorders prevent normal walking with an artificial limb in many amputees; Dr. Dederich discusses conservative and surgical methods of treatment of spinal, vasomotor, and causalgic pains and those of mixed types. Musculoplastic stump correction is a method of preparing physiologically all stump elements (muscle, bone, vessel ends, and nerve ends) and of establishing optimum relations among them. Many phantom pains and sensations are believed to be due to cramped and retracted musculature; by restoring normal muscular tension circulation is increased. Stumps prepared in the manner suggested here have become painless, warm, and muscularly strong.

AMPUTATION—PHYSICAL THERAPY

923. Kitabayashi, Betty *(Child Amputee Prosthetics Project, Univ. of California, Los Angeles, Calif.)*

The physical therapist's responsibility to the lower extremity child amputee. *Phys. Therapy Rev.* Oct., 1961. 41:10:722-727.

The physical therapist's responsibilities when working with child amputees are not the same as with adult amputees. The child cannot be dismissed from the therapist's schedule when he has learned to use his prosthesis; basic changes occur rapidly in the child due to growth rates and differences in walking patterns at various developmental levels. The therapist must prepare both the child and his parents for the use of a prosthesis, train the child, work to prevent deformities, and check the fit and function of the prosthesis periodically. These 4 areas of responsibility are discussed in some detail.

AMPUTATION—STATISTICS

924. Aitken, George T. *(Area Child Amputee Center, 920 Cherry St. S.E., Grand Rapids, Mich.)*

Hazards to health; etiology of traumatic amputations in children. *N. Eng. J. Med.* July 20, 1961. 265:133-134.

An analysis of a series of 203 amputations, performed

over the past 12 years at the Area Child Amputee Center, provides data on age, type of amputation, traumatic injury responsible for amputation, and sex of children. There were examples of unilateral, bilateral, and triple amputations in the 165 males and 38 females in the series. Accidents are classified under childhood recreation, thermal burns, household, railroad, vehicular, gunshot explosions, and farm and power tools. Implications of the findings for accident prevention measures are discussed briefly.

APHASIA—DIAGNOSIS

925. Wedell, W. J. *(490 Post St., San Francisco, Calif.)*

The language-handicapped child; coordinated evaluation by physicians and educators, by W. J. Wedell, E. A. Lown, and Russ Connor. *Calif. Med.* Apr., 1961. 94: 238-240.

Current methods of operation of the language program at the School for Cerebral Palsied Children, Northern California, San Francisco, are reviewed. Data on 70 children studied during 1959 because of neurological and major language problems are included. Findings of neurological and medical examinations and of psychological tests indicate the extent of medical and educational problems such children present. Composition of the diagnostic team at the School is given.

ARTHRITIS

926. New Jersey State Department of Health

The socio-cultural aspects of arthritis; a conference held in the Seton Hall College of Medicine, Jersey City, March 30, 1961. *Public Health News,* N.J. State Dept. of Health. Oct., 1961. 42:10:291-308.

Papers presented in this issue of *Public Health News* were given during a panel discussion moderated by Ronald Lamont-Havers, medical director of The Arthritis and Rheumatism Foundation. The Conference was sponsored by the New Jersey State Department of Health, New Jersey Rheumatism Association, and the New Jersey Arthritis Project.

Contents: Opening remarks, Ronald Lamont-Havers.—Arthritis and the anthropologist, Edwin Wellin.—A research approach to visible disability, Stephen A. Richardson.—Psycho-social factors in rheumatoid arthritis, Stanley H. King.—The bearing of genetics and epidemiology on social and cultural aspects of arthritis, Baruch S. Blumberg.—Discussion and summary, Ronald Lamont-Havers.

Public Health News is published monthly by the State Dept. of Health, Trenton 25, N.J. Reprints of this issue are available on request to the Department.

ARTHRITIS—PHYSICAL THERAPY

927. Flatt, Adrian E. *(University Hospitals, State Univ. of Iowa, Iowa City, Iowa)*

Rheumatoid hand; physical therapy following insertion of Flatt prosthesis, by Adrian E. Flatt and Whitney R. Powers. *Phys. Therapy Rev.* Oct., 1961. 41:10:709-713.

Postoperative care and physical therapy technics used in maintaining active power in the posthetic joints of the Flatt prosthesis are described. The prosthesis is an articulated metallic hinge placed as a substitute for grossly destroyed or dislocated digital joints of the rheumatoid hand. Specific exercises are given for a home therapy program; these should consist primarily of domestic procedures for female patients. Male patients are given a more directly supervised exercise program to keep their incentive high. Progressive resistive exercises are not used. Periodic re-evaluation of patients' progress is essential.

AUDIOMETRIC TESTS

928. American Speech and Hearing Association. Committee on Identification Audiometry

Identification audiometry; a report . . . by the . . . ed. by Frederic L. Darley. Washington, D.C., The Assn., 1961. 68 p. figs., tabs. *(J. Speech and Hear. Disorders. Monograph suppl. no. 9. Sept., 1961)*

The National Conference on Identification Audiometry, arranged by the American Speech and Hearing Association through a grant from the U.S. Children's Bureau, brought together experts in hearing and hearing tests to formulate guidelines on audiometric standards and procedures for screening and monitoring programs. The Conference proceedings covered many aspects of program development, procedures, problems of personnel and management, interpretation, and follow-up, in regard to preschool children, school health programs, and aspects of industrial and military audiology. Material in this supplement is based on the proceedings. Additional material in the appendixes includes 3 papers: Laws and regulations in identification audiometry; direction and trends, Don A. Harrington.—Hearing levels in children and implications for identification audiometry, Eldon L. Eagles.—Steps toward an international audiometric zero, J. Donald Harris.

Available from American Speech and Hearing Assn., 1001 Connecticut Ave., N.W., Washington, D.C., at $1.90 a copy.

See also 907.

BLIND

See 904; 986.

BRACES—GERMANY

929. Habermann, Helmut

Clinical practice of orthotics in Germany. *Orthopedic & Prosthetic Appliance J.* Sept., 1961. 15:3:238-260.

Types of orthopedic equipment, corsets, and bandages and their variations, as prescribed in Germany for patients with disabilities from poliomyelitis, disorders of the hip joint, fracture of the thigh, scoliosis, morbid changes of the spine, paralysis of the upper extremity, talipes cavus, and rupture of the symphysis, are described and illustrated. The article is based on a lecture given by Mr. Habermann at the 1961 National Assembly of the American Orthotics and Prosthetics Association. A number of the newest technics in Germany have been developed by the author.

On p. 305 of this issue of the *Journal* is a supplement to the Glossary of German Brace Names that appeared in the March, 1960, issue (p. 58-59). The supplementary list was prepared by Erich Hanicke. Additional lists of terms that have not yet appeared will be welcomed by the *Journal.*

CEREBRAL PALSY—DIAGNOSIS

930. Rosner, Samuel *(1882 Grand Concourse, Med. Arts Bldg., Bronx 57, N.Y.)*

The relationship between the epilepsy of cerebral palsy and the electroencephalogram. *Arch. Pediatrics.* July, 1961. 78:269-271.

In a series of cases (142 children between the ages of 6 months and 13 years), 110 patients were found to have epilepsy. Electroencephalograms were done in 56, with 7 children having repeat tracings done. Surgical pathology in 68 children, clinical signs, and electroencephalographic findings are reviewed. Dr. Rosner gives his definition of complicated cerebral palsy and concludes that there can be no cerebral palsy without cerebral pathology. Despite the local pathology, the electroencephalogram in almost every case shows generalized abnormality; it is his belief that the abnormality is due to hypoxia of the brain because of defective vascularization.

See also 925.

CEREBRAL PALSY—SPEECH CORRECTION

See 982.

CEREBRAL THROMBOSIS

See 912.

CHRONIC DISEASE

931. Denver. University. School of Social Work

Proceedings of the workshop on services to the chronically ill person, August 17-21, 1959. Washington, D.C., U.S. Public Health Service, 1961. 71 p. tabs.

Objective of the Workshop was to provide case workers in the Colorado Department of Public Welfare with an opportunity to learn and share knowledge and experience related to services for the chronically ill, particularly those with heart disease, and to understand the need for co-ordinating public health and welfare services. The proceedings contain papers presented at the general sessions, summary reports of group discussions, and appended material—case analyses, questionnaire form, bibliography, and evaluation guide.

Partial contents: The socio-economic aspects of cardiac disease and chronic illness, Robert Hansen.—The impact of illness on the patient and his family, Eileen Lester.—Current problems, Norma Fuller.—Understanding of childhood and congenital heart disease, John Lichty.—Understanding of adult cardiac disease, Arthur Rikli.—Colorado Work Classification Unit, Loring Brock and Jane Spencer.—Craig Rehabilitation Center, Frank Murphy.—Colorado State Department of Rehabilitation, Warren Thompson.—Trends and issues, Pauline Ryman.

Distributed by U.S. Public Health Service, Washington 25, D.C.

CHRONIC DISEASE—INSTITUTIONS

932. Novick, Louis J. *(Montreal Hebrew Home for the Aged, Montreal, Can.)*

Occupational therapy and social group work in the home for the sick aged; a comparison. *Am. J. Occupational Ther.* Sept.-Oct., 1961. 15:5:198-203, 211.

Both the occupational therapist and the social worker use group work to help individuals achieve growth according to their needs and capacities. Occupational therapy, however, is concerned only with helping the sick. In homes for the aged sick, the role of both workers is identical. The author suggests that student occupational therapists be provided with more training in the theory of group work. Criteria for guiding the home for chronically ill older persons in its use of occcupational therapist and social group worker are discussed.

CLOTHING

933. Cookman, Helen

Functional fashions for the physically handicapped, by Helen Cookman and Muriel E. Zimmerman. New York, Institute of Phys. Med. and Rehabilitation, 1961. 80 p. illus., graphs, charts. *(Patient publ. no. III)* Paperbound. Spiral binding.

Describing basic problems of clothing for the physically handicapped and features designed to overcome them, this monograph offers many ideas that may be used in adapting ready-to-wear clothes or patterns. Clothing problems, analyzed from observations of patients during practice of dressing activities, are charted, with suggested solutions where various types of disability pose difficulties. Clothing for children and adults is illustrated and discussed. Betty Wadsworth has contributed a section in the appendix on "Basic textile information for rehabilitation"; instructions for washing, ironing, and cleaning of clothing are also included. This booklet was produced as part of a research project aided by a grant from the U.S. Office of Vocational Rehabilitation; the Clothing Research and Development Foundation is continuing the work begun by the Institute.

Available from Publications Unit, Institute of Physical Medicine and Rehabilitation, 400 E. 34th St., New York 16, N.Y., at $1.00 a copy.

COLLEGES AND UNIVERSITIES

934. Kammerdiener, F. Leslie, Jr. *(Wayland Baptist Coll., Plainview, Tex.)*

Fundamental facts relating to the counseling and higher education of epileptic persons. *Mental Hygiene.* Oct., 1961. 45:4:552-562.

A review of the symptoms and causal factors of epilepsy, studies of intelligence in epileptic persons seen as private patients, their educational level, and the environmental causes preventing normal social contacts and educational opportunities. Restrictions on epileptic persons in school life are examined, the statistical information concerning incidence of epilepsy in relation to school size and admission policies is analyzed. Much of the literature has been reviewed in the preparation of this article.

CONGENITAL DEFECT

935. Warkany, Josef *(Univ. of Cincinnati Coll. of Medicine, Elland and Bethesda Aves., Cincinnati 29, Ohio)*

Intrauterine growth retardation, by Josef Warkany, Berry B. Monroe, and Betty S. Sutherland. *Am. J. Diseases of Children.* Aug., 1961. 102:2:249-279.

A brief review of the literature on infants with marked

intrauterine growth retardation indicates that those surviving the neonatal period develop normally. However scattered reports suggest that physical and/or mental development continues unsatisfactorily in postnatal life and leads to temporary or permanent stunting. The 27 case reports included here illustrate the serious problems such children often present during childhood. It is the authors' opinion that such developmental disturbances are much more common in children with normal birth weight, although this point cannot be proved by observations in this series. 90 references.

See also 941.

DEAF

See p. 365.

DEAF—SPECIAL EDUCATION

936. Connally, Eileen E. *(Horace Mann Day School for the Deaf, Kearsarge Ave., Roxbury 19, Mass.)*

Implications of research for the classroom teacher. *Am. Annals of the Deaf.* Sept., 1961. 106:4:397-404.

Responsible teachers of the deaf should be aware of current research findings and their implications for educational planning and methods. Practical suggestions are offered for overcoming weaknesses of deaf children in the learning process—social immaturity, weak visual memory span, especially for digits, and lack of abstract reasoning ability. This paper was presented at a symposium on social-psychological problems of children with hearing impairment, held at the 1961 meeting of the Council for Exceptional Children.

See also 915.

DEAF—SPEECH CORRECTION

937. Mangan, Kenneth R. *(Illinois School for the Deaf, Jacksonville, Ill.)*

Speech improvement through articulation testing. *Am. Annals of the Deaf.* Sept., 1961. 106:4:391-396.

A variation of the appraisal method described in a Dec., 1949, article appearing in *Volta Review* was used to obtain a measure of the intelligibility of speech of 30 children (grades 2, 4, 5, and 7) at Gallaudet Day School for the Deaf, St. Louis. Teachers, parents of deaf children, and college students were employed as listeners. Other objectives of the articulation testing were: to discover speech sounds most frequently misunderstood by listeners; to compare ability of 3 groups of listeners in understanding deaf children's speech; and to focus attention of pupils, parents, and teachers on the need for careful production of speech sounds. Implications of the findings and the value of articulation testing are discussed briefly.

938. Watson, T. J. *(Dept. of Education of the Deaf, Univ. of Manchester, Manchester, Eng.)*

The use of residual hearing in the education of deaf children. *Volta Rev.* Sept. & Oct., 1961. 63:7 & 8. 2 pts.

Both articles are part of a series based on a lecture course given at the University of Manchester in 1961; other parts will appear in subsequent issues of *Volta Review.* The entire series will be published in book form, available from the Alexander Graham Bell Association for the Deaf in late spring of 1962. Discussion here is mainly on the use of residual hearing in children whose hearing loss is considered severe. Dr. Watson points out the usefulness of various tests in determining children's potential for learning to discriminate speech sounds (Part I); in Part II acoustical patterns of speech, determined by the manner in which sounds are formed in the vocal tract, are examined. Other characteristics of speech—intonation, rhythm and stress, and duration—that contribute to naturalness and intelligibility are also discussed.

DRAMATICS

See 917.

DRUG THERAPY

939. Diamond, Eugene F. *(11055 S. St. Louis Ave., Chicago 55, Ill.)*

Neuromuscular development in mongoloid children, by Eugene F. Diamond and Myong Sun Moon. *Am. J. Mental Deficiency.* Sept., 1961. 66:2:218-221.

Fifty children being cared for at home or in a private institution (Misericordia Home, Chicago) received dehydroepiandrosterone, dessicated calves' pituitary, or nandrolone phenpropionate in an attempt to stimulate their neuromuscular performance. None had received previous specific therapy; age at onset of therapy ranged from 2 months to 31 months. No undesirable side effects were observed but there was no evidence of any beneficial effects on intelligence in any of the treated groups. The slight improvement in muscle tone in children treated with dehydroepiandrosterone and nandrolone phenpropionate did not result in statistically significant improvement in neuromuscular development.

EMPLOYMENT (INDUSTRIAL)

See 916.

EPILEPSY

See 930; 934.

HANDICAPPED—BIOGRAPHY

See 908.

HANDICRAFTS

See 918.

HEMIPLEGIA

See 912; 976.

HEMIPLEGIA—DIAGNOSIS

940. Birch, Herbert G. *(Dept. of Pediatrics, Albert Einstein Coll. of Med., Bronx 61, N.Y.)*

Visual verticality in hemiplegia; visual influences on perception, by Herbert G. Birch (and others). *Arch. Neurol.* Oct., 1961. 5:4:444-453.

Judgments of the verticality of a rotated luminous rod alone, and when the rod appeared within a luminous square frame, made by 20 brain-damaged (hemiplegic) patients and 18 nonbrain-damaged patients (orthopedically handicapped), were compared. All testing was con-

ducted in a completely darkened room. When the rod was shown alone, brain-damaged patients were significantly more variable in judgments than were the neurologically normal group. With the introduction of the frame, variability decreased in the hemiplegic group and increased in nonhemiplegics. The frame appeared to exert a scattering tendency on judgments of the latter in contrast with its tendency to homogenize performance of hemiplegics. Findings are interpreted in terms of the relative availability of intersensory and intrasensory integration for hemiplegics and nonhemiplegics. For additional papers on visual perception in hemiplegics, see *Rehab. Lit.*, Nov., 1961, #868.

HEREDITY

941. Hurst, Lewis A. *(Univ. of Witwatersrand, Johannesburg, S. Afr.)*

Applications of genetics in psychiatry and neurology. *Eugenics Quart.* June, 1961. 8:2:61-80.

Based on an article of similar title in: *S. African J. Laboratory and Clinical Med.* Sept., 1958. 4:3.

Scientific methods of research in human genetics are discussed briefly; a condensation of some of the main findings and recent research in the fields of psychiatry and neurology relating to genetic mechanisms operating in certain conditions is included. A review of the nature of phenylketonuria illustrates the relation of biochemical and mental defect, adding a new dimension to genetics. Implications of research findings for further study, the role of eugenics and heredity clinics in relation to neuropsychiatric conditions, and the function and operation of heredity counseling services are considered.

HOMEBOUND—PROGRAMS

942. American Hospital Association

Principles of administration of hospital-based coordinated home care programs. Chicago, The Assn., 1961. 10 p.

This statement approved by the American Hospital Association's Board of Trustees contains guiding principles on the administrative structure of home care programs for selected patients, the services to be provided, staffing and supportive services, minimum rules for admission policies, financing, and record keeping. The Association plans to supplement the statement by issuing information on uniform procedures for keeping statistical and financial records.

Available free from American Hospital Association, 840 N. Lake Shore Dr., Chicago 11, Ill.

943. American Medical Association. Council on Medical Service

How to plan a community homemaker service. Chicago, The Assn., 1961. 32 p. forms.

This manual, prepared by the Committee on Community Service of the Woman's Auxiliary of the American Medical Association, suggests plans and procedures adaptable to the individual community's program of homemaker services. Functions of the service, primary goals, qualifications needed by the homemaker, management of requests for service, and steps in setting up a state-wide program are discussed. Organization and structure of the group administering the program, selection of staff, financing, recruiting and training of homemakers, and provision of services are outlined briefly. Use of standard forms, illustrated here, is recommended to facilitate all homemaker service operations. Additional references useful in planning are included.

Available from American Medical Association Council on Medical Service, 535 N. Dearborn St., Chicago 10, Ill.

See also 974.

MENTAL DEFECTIVES

944. Windle, Charles D. *(Pacific State Hosp., Pomona, Calif.)*

Reasons for community failure of released patients, by Charles D. Windle, Elizabeth Stewart, and Sheldon J. Brown. *Am. J. Mental Deficiency.* Sept., 1961. 66:2: 213-217.

Three groups of institutionalized patients placed on vocational leave, home leave, and family care were investigated in a follow-up study for 4 years from the date of release. Failures on vocational leave were most frequently due to inadequate work performance, interpersonal relations, and voluntary departure from the leave situation. Antisocial behavior accounted for most failures on home leave. In family care, failure was due mainly to environmental lack of support, poor health, or intolerable behavior. A review of 10 studies found in the literature, reporting reasons for failure to adjust in the community, revealed similar findings. Points of dissimilarity are examined.

MENTAL DEFECTIVES—DIAGNOSIS

See 907; 987.

MENTAL DEFECTIVES—EMPLOYMENT

945. Cohen, Julius S. *(Syracuse Univ., Div. of Special Education and Rehabilitation, Syracuse, N.Y.)*

A five phase vocational training program in a residential school, by Julius S. Cohen and Charles E. Williams. *Am. J. Mental Deficiency.* Sept., 1961. 66:2:230-237.

The program including prevocational evaluation, on-campus training, day work in a community work-training program, and extended leave (the terminal phase when the student is employed and lives in the community) is designed to develop the full potential of residential school retardates. Group and individual vocational counseling services, provided throughout the 5-phase program, are the key to student adjustment and self-help. Organization and administration of such a program within the residential school are discussed. A brief review of the program by Joseph J. Parnicky (and others) appeared in *Rehab. Record*, July-Aug., 1961 (see *Rehab. Lit.*, Oct., 1961, #777).

946. Kolstoe, Oliver P. *(704 S. Forest St., Carbondale, Ill.)*

Employability prediction for mentally retarded adults; a methodological note, by Oliver P. Kolstoe and Albert J. Shafter. *Am. J. Mental Deficiency.* Sept., 1961. 66:2: 287-289.

The authors suggest that attempts to determine potential for employability and ability to work successfully require

a differential analysis of vocational and social behavior. One approach might involve an attempt to describe accurately jobs already held successfully according to intellectual, personal, social, and vocational skill. Validation of the classification system would be apparent if no mentally retarded adult was successfully employed at a level above his over-all level of skill. The Southern Illinois University Training Center has already classified some 30 workshop tasks according to level of complexity and is attempting to use the same system to evaluate skills and abilities of clients.

MENTAL DEFECTIVES—PROGRAMS

947. Tramburg, John W. *(New Jersey Dept. of Institutions and Agencies, Trenton 25, N.J.)*

Future aspects of state governmental programs. *Am. J. Mental Deficiency.* Sept., 1961. 66:2:205-212.

Responsibility for operation of a public program should be fixed at the lowest level of government where the job can be carried out in the most effective and economical way. The present major functions of state governments in this area will continue in the future, it is hoped, with improvement of institutional care. Four less traditional areas where the state should accept responsibility are: the development of general welfare programs that offer solutions for the mentally retarded's problems; research; program development or long-range planning; and professional and staff development.

MENTAL DEFECTIVES—PSYCHOLOGICAL TESTS

948. Barksdale, Mildred W. *(Atlanta Univ., Atlanta, Ga.)*

Social problems of mentally retarded children. *Mental Hygiene.* Oct., 1961. 45:4:509-512.

Placement in special classes does not assure mentally retarded children social acceptance among their classmates. A sociometric test given 390 mentally retarded children in elementary special classes in North Carolina revealed reasons why 94 were rated by their peers as "popular." Evidence of greater social maturity among the popular children suggests that teachers could further acceptance of those less popular by helping them develop more of the behaviors and skills measured by the Vineland Social Maturity Scale. Teachers can help pupils improve their mental health by attacking some of the problems of personal and social adjustment; acceptance by others is important regardless of mental level.

949. Berkson, Gershon *(Yerkes Laboratories of Primate Biology, Orange Park, Fla.)*

Responsiveness of the mentally deficient. *Am. J. Mental Deficiency.* Sept., 1961. 66:2:277-286.

A review of laboratory studies of the behavior of the mentally handicapped, involving relatively simple stimulus-response sequences. Two aspects of response—speed and amount—were subjects of all the investigations discussed here. Although speed of physiological responses does not seem to differentiate normals from defectives, it has been shown consistently that speed of voluntary responses is slower in mentally deficient groups. Possible causes of slowness of response are discussed, with some hypotheses presented that might profitably be applied to data found in the studies. Suggestions for areas of future research are offered. 52 references.

950. Goldstein, Herbert *(Institute for Research on Exceptional Children, Univ. of Illinois, Urbana, Ill.)*

Incidental learning of educable mentally retarded and gifted children, by Herbert Goldstein and Corinne Kass. *Am. J. Mental Deficiency.* Sept., 1961. 66:2:245-249.

Performance on an incidental learning test was compared in 21 educable mentally retarded children attending special classes and 21 gifted children of the same mental age enrolled in nursery school. In tasks that measure gross features of incidental learning, retarded children appear to perform, quantitatively and qualitatively, as well as gifted children of the same M.A. As tasks become more complex, however, the retarded are significantly more inaccurate than the gifted. Implications for the planning and administration of classroom activities for the mentally retarded are discussed.

951. Guthrie, George M. *(Dr. Butler, Laurelton State Village, Laurelton, Pa.)*

Patterns of self-attitudes of retardates, by George M. Guthrie, Alfred Butler, and Leon Gorlow. *Am. J. Mental Deficiency.* Sept., 1961. 66:2:222-229.

A report of a study designed to identify groups of retardates with similar constellations of self-attitudes. Reliability of the 150-item self-attitude questionnaire was assessed by retesting 100 institutionalized and non-institutionalized female retardates, ranging in age from 14-18 years and with an IQ range of 50 to 80. There are 7 factors or variables in the questionnaire, 3 of which represent essentially favorable outlooks. Ability to assess individual differences in the retarded will aid in planning treatment programs since response to treatment will be influenced by factors within the realm of the self-attitudes.

952. Meyers, C. E. *(Pacific State Hosp., Pomona, Calif.)*

Comparative abilities of normals and retardates of M.A. 6 years on a factor-type test battery, by C. E. Meyers (and others). *Am. J. Mental Deficiency.* Sept., 1961. 66:2:250-258.

Normal school children 6 years of age were compared with retarded hospitalized patients with a mental age of 6 years on tests of hand-eye skill, perceptual speed, linguistics, and nonverbal reasoning. The school group surpassed the retardates on all but expressive vocabulary; retardates were poorest on reasoning and digit span tests. Results of the 13-test battery support the hypothesis of cumulated experience versus ability to deal in complexities; retarded persons of greater chronological age will have cumulated more bits of easy information and vocabulary.

953. Miller, Martin B. *(George Peabody Coll., Nashville, Tenn.)*

The effects of training verbal associates on the performance of a conceptual task, by Martin B. Miller and Belver C. Griffith. *Am. J. Mental Deficiency.* Sept., 1961. 66:2:270-276.

Results of this experimental research conducted at Edward R. Johnstone Training and Research Center indicated that social reinforcement of relevant or irrelevant associates of words appearing as a set in an abstraction test had no apparent effect on abstraction performance

of retardates in the trained group. When trained and untrained students' performance was compared, those in the trained group did significantly better on test items composed of nouns used in training but not better than the untrained on materials *not* used in pretraining. Any improvement in the conceptual behavior of retardates, effected through training, may be limited to the materials used in training.

954. Reger, Roger *(Wayne County Training School, Northville, Mich.)*

The use of psychological tests to predict manual abilities in mentally retarded boys, by Roger Reger and Antoinette Dawson. *Am. J. Occupational Ther.* Sept.-Oct., 1961. 15:5:204, 221.

Test results of 23 emotionally disturbed, mentally retarded boys (11 to 15 years of age) on the Wechsler Intelligence Scale and the Bender Visual Motor Gestalt Test did not relate positively to gross motor ability, as rated by the occupational therapist. Findings imply that test scores alone are not sufficient for making a prediction about actual performance in occupational therapy. It is quite probable that motivation and personal relationships with the therapist are of primary importance.

955. Smith, Maurice P. *(Dept. of Psychology, Univ. of Colorado, Boulder, Colo.)*

Effects of type of stimulus pretraining on discrimination learning in mentally retarded, by Maurice P. Smith and John R. Means. *Am. J. Mental Deficiency.* Sept., 1961. 66:2:259-265.

Results of testing 85 mental defectives, aged 13 to 45 (IQ's 35 to 85), on a task requiring learning to press 1 of 3 buttons in response to visual stimuli indicated that pretraining conditions had positive transfer value to the button selection task. Meaningful names or hand movements, used as cues, had greater transfer value than nonsense syllable names for the visual stimuli. Of the stimulus pretraining conditions used in this study, the type most likely to contribute to an acquired distinctiveness of cues with mentally defective persons would seem to involve meaningful labeling, verbal or motor in nature.

MENTAL DEFECTIVES—SOCIAL SERVICE

956. Katz, Alfred H., ed.

Mental retardation and social work education; proceedings of a conference held at Haven Hill Lodge, Milford, Michigan, June 16-19, 1959. Detroit, Wayne State Univ. Pr., 1961. 56 p.

Major emphasis of this study sponsored by the American Association on Mental Deficiency and the Council on Social Work Education was on the role of the social worker in the field of mental retardation, an evaluation of the current background of professional education and experience in this area, and how schools of social work could incorporate relevant content into the curriculum to meet social workers' needs.

Contents: Introduction; the background of the conference, Katherine A. Kendall and Darrell A. Hindman.—Conference position statement, Charles B. Brink and Joseph J. Parnicky.—Mental retardation as a social problem, Michael J. Begab.—Social work services to the retarded, Frances M. Coakley.—Social work education for services to the retarded, Alice L. Peck.—The challenge of mental retardation to social work education (summary of group reports), Alfred H. Katz.

Available from Wayne State University Press, Detroit 2, Mich., at $1.50 a copy.

MENTAL DEFECTIVES—SPECIAL EDUCATION

957. U.S. Office of Education

Education of the severely retarded child; classroom programs, prepared by Harold M. Williams. Washington, D.C., Govt. Print. Off., 1961. 82 p. tabs. *(OE-35022; Bul. 1961, no. 20)*

Suggestions for developing classroom programs for "trainable" children are based on findings from current literature and on the joint experience of persons who collaborated in preparation of the publication. Sections I and II, on characteristics of severely retarded children and on classroom programs, were contributed by Harold M. Williams. Section III, "Teacher Selection and Preparation," was prepared by Frances P. Connor, and Section IV, on some administrative considerations, is the work of Jennie Brewer. Specifically covered are: legislative and regulatory definitions of severe mental retardation, medical classifications, and behavior characteristics; principles and objectives of curriculum planning; organization of curriculum materials and activities used with success in classes for the trainable; a sample analysis of a daily program of activities; and administrative procedures in the establishment of special classes in the community.

Available from U.S. Superintendent of Documents, Government Printing Office, Washington 25, D.C., at 45¢ a copy.

MENTAL DEFECTIVES—SPEECH CORRECTION

See 907; 914.

MENTAL DISEASE—PROGRAMS

958. Harrison, Emma

Mental aftercare; assignment for the sixties. New York, Public Affairs Committee, c1961. 28 p. *(Public Affairs pamph. no. 318)*

This pamphlet discusses problems of released patients, types of aftercare programs, and the role of professional personnel and volunteers in program administration. Comprehensive services for former mental patients in all states is the goal; current lack of personnel is hampering success of the program.

Available from Public Affairs Pamphlets, 22 E. 38th St., New York 16, N.Y., at 25¢ a copy (less in quantity orders).

See also 913.

MENTAL DISEASE—RECREATION

959. Wechsler, Henry *(74 Fenwood Rd., Boston 15, Mass.)*

Patterns of membership in a self-help organization in mental health. *Mental Hygiene.* Oct., 1961. 45:4:613-622.

Studies of characteristics of those who join voluntary social, civic, fraternal, and religious associations revealed consistent differences between joiners and nonjoiners in the community. A similar study of the membership of

Recovery, Inc., the largest and oldest self-help organization in the mental health field, showed that members exhibited many of the same personal characteristics attributed to the joiner in general. In addition, members were found to be relatively active in other voluntary community organizations. If such selectivity of membership does exist, the utilization of self-help organizations in the field of rehabilitation may be limited to only certain segments of the population of persons with psychiatric difficulties or physical handicaps.

MONGOLISM

960. Share, Jack *(1160 McComb Way, Monterey, Calif.)*

A preliminary investigation of the early developmental status of mongoloid infants, by Jack Share, Allen Webb, and Richard Koch. *Am. J. Mental Deficiency.* Sept., 1961. 66:2:238-241.

A report of a longitudinal study of 16 mongoloid infants at the Child Development Clinic, Los Angeles Children's Hospital; all were outpatients living at home and had been given a Gesell Examination at least once a year over a 3-year period. It was found that developmental quotients obtained during the first year of life have little, if any, predictive value in mongoloid children; quotients obtained during the second year of life are valid predictors of future DQ's. Development of mongoloid infants follows a pattern of slow, steady improvement; data as yet are insufficient to establish at what age a possible plateau of development is reached.

See also 939.

MULTIPLE SCLEROSIS—DIAGNOSIS

961. Kurtzke, John F. *(VA Hosp., Coatesville, Pa.)*

On the evaluation of disability in multiple sclerosis. *Neurology.* Aug., 1961. 11:8:686-694.

The complementary 2-part scale used for disability rating in patients with multiple sclerosis employs a series of 8 functional groupings to record neurologic findings, with a disability status scale to show progression of the disease as it usually occurs. The method represents, in the author's opinion, the best available device for measuring severity of neurologic impairment. Use of the disability status scale permits comparison within or among groups over a period of time. Appendixes contain outlines of the 2-part scale and data from evaluation of more than 400 patients.

OLD AGE—OCCUPATIONAL THERAPY

See 932.

ORTHOPEDICS—EGYPT

962. Rida, Amin *(Alexandria Schools Hosp., Alexandria, Eg.)*

Common orthopaedic problems in school children of Alexandria. *Alexandria Med. J.* July, 1961. 7:4:400-409.

Children attending state schools (public) are given medical care at the Alexandria Schools Hospital; this article is a classification by etiology of conditions for which 1,571 children were seen in the orthopedic department of the hospital during 1958. Traumatic injuries comprised the majority (82.1%), the greater part of which were of a minor nature. Fractures of the upper extremity were 4.6 times more common than those of the lower limb. In this series of patients, fractures were about 45 times more frequent than dislocations; congenital dislocation of the hip is rare in Egypt and was not represented here. Statistical findings are compared with those reported in similar studies found in the literature. Various groups of orthopedic diseases among school children are discussed.

OSTEOCHONDRITIS

963. Ralston, Edgar L. *(3400 Spruce St., Philadelphia, Pa.)*

Legg-Calvé-Perthes' disease; orthopedic care, by Edgar L. Ralston; Nursing care during the long rest period, by Lucy L. Buck. *Am. J. Nursing.* Oct., 1961. 61:10:88-92.

Incidence, etiology, pathology, symptoms, clinical examination, and treatment of this self-limited disease of the hip joint are discussed by an orthopedic surgeon who states the general consensus regarding treatment is that these patients be kept on a nonweight-bearing regimen. Light traction and a definite program of exercises to maintain muscle tone in the hip and extremity are recommended until a certain stage in the healing process has been reached.

Miss Buck *(Children's Seashore House, Atlantic City, N.J.)* discusses problems of keeping the child who is hospitalized with this disease content during the many months' immobilization. General nursing care and technics to prevent contractures and deformity are mentioned.

PARALYSIS AGITANS—MEDICAL TREATMENT

964. Cooper, Irving S. *(St. Barnabas Hosp. for Chronic Diseases, 183rd St. & 3rd Ave., New York 57, N.Y.)*

A multidiscipline approach to rehabilitation in Parkinsonism, by Irving S. Cooper and Manuel Riklan. New York, St. Barnabas Hospital for Chronic Diseases, 1961. 44 p. illus., tabs.

Reprinted from: *St. Barnabas Hosp. Med. Bul.* Spring, 1961.

This monograph, summarizing experience of a 3-year multidisciplinary project in the rehabilitation of patients with Parkinson's disease, describes procedures in the selection of patients to undergo neurosurgery, technics of chemopallidectomy and chemothalamectomy, and the postoperative rehabilitation program. Data concerning immediate and long-range effects of surgery, with special emphasis on neurologic symptoms, functional activities, and vocational status for long-range patients, are included. It was found that relatively young and unilateral patients benefit most from multidisciplinary rehabilitation; some unemployed for many years were returned to gainful employment. Chemosurgery in appropriate situations can serve as preventive rehabilitation, extending the work lives of those still employed when rehabilitation efforts are successful.

PARAPLEGIA—EQUIPMENT

965. McBride, Helena D. *(VA Hosp., Long Beach, Calif.)*

Useful adaptation devices for quadriplegics, by Helena

D. McBride and Ernest Bors. *Am. J. Occupational Ther.* Sept.-Oct., 1961. 15:5:205-209.

Adapted equipment that an occupational therapist with some mechanical ability can construct easily and at minimum expense is pictured and described. Included are an adaptation of a Zippo-type cigarette lighter, a holder for Schick ejector-type razor, spoon and fork on metal bands, u-shaped plastic writing splint, and a comb or toothbrush with leather strap on dowel rod. Use of the equipment has saved many hours of nursing time on the Long Beach VA Hospital's spinal cord injury service.

PARAPLEGIA—MEDICAL TREATMENT

966. Fikry, Essam *(Alexandria University, Alexandria, Eg.)*

A study of the liver in paraplegics, by M. Essam Fikry and M. El-Gazayerly. *Alexandria Med. J.* July, 1961. 7:4:419-426.

Findings of a clinical study of the liver in 25 patients with paraplegia, admitted to Alexandria University Hospitals. A majority of the patients showed deranged protein and carbohydrate metabolism and sulfobromophthalein retention; there was no hepatic cellular change but liver cells had a tendency to glycogen storage inside their nuclei. Improvement of the paralytic condition was accompanied by improvement in these hepatic functions. A possible explanation of the findings is made on the basis of the pathological physiology. Nineteen patients in this series had acute transverse myelitis at levels from the 6th to the 10th thoracic spinal segments; 5, at higher levels; and one at a lower level (cauda equina).

PEDIATRICS

967. Glaser, Helen H. *(4200 E. Ninth Ave., Denver, Colo.)*

Studies of comprehensive medical care for handicapped children: II. Relationships of doctors-in-training with pediatric out-patients, by Helen H. Glaser, David B. Lynn, and Grace S. Harrison. *J. Med. Education.* Oct., 1961. 36:10:1283-1294.

Factors in the relationships of 80 pediatric patients and their mothers with fellows, residents, and interns in the University of Colorado Medical Center's pediatric outpatient department were analyzed as part of the overall study of comprehensive medical service to handicapped children. Findings indicated the doctor-patient relationship was not hindered by the physical facilities or the structuring of patient contact. Positive attributes of physicians' manner of establishing rapport with mother and child were evaluated, complexity and clarity of verbal interchange were assessed, and reassurance and support by the doctor were judged according to appropriateness. The differences noted among doctor categories in the establishment of patient relationships were thought to be the result of a number of factors. The educational role of the outpatient department in graduate education is noted.

PHYSICAL EFFICIENCY

See 960; 961.

PHYSICAL THERAPY

See 911.

POLIOMYELITIS—PROGRAMS

968. Sweet, Avron Y. *(Mt. Sinai Hosp., Fifth Ave. at 100th St., New York, N.Y.)*

Social and functional rehabilitation of patients with severe poliomyelitis, by Avron Y. Sweet and Esther White. *J. Mt. Sinai Hosp.* July-Aug., 1961. 28:4:366-380.

Application of improved technics of care for patients with severe physical handicaps, developed at the Jack Martin Poliomyelitis Clinical Study Center, Mt. Sinai Hospital, has proved effective in supplementing and complementing strictly medical care. Technics used during and after hospitalization that have resulted in restoration of function, productivity, personality, and dignity are discussed in some detail. Analysis of results in 86 chronic poliomyelitis patients who required the use of some type of respirator during or after hospitalization is included. The role of the social worker at the Center is explained. Two case histories illustrate the need for understanding personality factors and the working out of vocational rehabilitation plans with those factors in mind.

POSTURE

969. Burt, Hugh

Faulty posture: I. Signs and symptoms; II. Treatment; III. Results, by Hugh Burt and Molly Turner. *Physiotherapy.* Aug. & Sept., 1961. 47:8 & 9. 2 pts.

Physiological principles relating to posture, methods for assessing posture in the lateral and posteroanterior standing and lateral sitting positions, and the clinical effects of faulty posture on the musculoskeletal system and on general health and well-being are discussed in Part I. Psychological effects of faulty posture resulting in pain can cause mental disturbance and personality changes. Postural re-education can bring about considerable, and often lasting, improvement. The aims of treatment and the role of the physical therapist are defined in Part II; formal exercises are omitted but active relaxation is taught. Interview technics are explained; duration of treatment and follow-up are planned in accordance with the individual patient's needs. Part III contains an analysis of results of treatment in 50 patients.

PSYCHOLOGICAL TESTS

970. Darley, Frederic L. *(Dept. of Speech Pathology, State Univ. of Iowa, Iowa City, Iowa)*

Comparison of male and female kindergarten children on the WISC, by Frederic L. Darley and Harris Winitz. *J. Genetic Psych.* 1961. 99:41-49.

A previous report on the standardization procedure for the Wechsler Intelligence Scale for Children indicated, in the final analysis, some small sex differences in IQ scores. This investigation, by essentially replicating the WISC standardization procedure, attempted to determine whether statistically significant sex differences are apparent on WISC IQ scales and subtest scores and whether sex differences are apparent between correlations computed between any 2 WISC measures. Although statistically significant differences favoring girls were found on the Performance Scale IQ and on the Similarities and Coding A Sub-tests, differences between correlations, computed for boys and girls separately, were significant in only a few instances. In general, mean IQ scores and intercorrela-

tions compare very closely with WISC norms for children of comparable age levels.

971. **Hirschenfang, Samuel** *(848 E. 28th St., Brooklyn 10, N.Y.)*

A comparison of the revised Columbia Mental Maturity Scale (CMMS) and Goodenough Draw-a-Man Test in children with speech disorders. *J. Clinical Psych.* Oct., 1961. 17:4:381-382.

Correlation of CMMS and Draw-a-Man test scores of 61 children with various speech disorders was sufficiently high to warrant the assumption that both tests can be used in evaluating the intellectual functioning of children with speech disorders. Diagnoses assigned to the children following extensive evaluation were: cleft palate, mental retardation, brain damage, stuttering, articulation disorders, delayed speech, and hard of hearing. All of the children had higher IQ's on the CMMS than on the Goodenough test; girls tended to perform better on both tests than did the boys. In previous studies on the CMMS and the Binet, sex factors did not affect the scores.

PSYCHOLOGY

972. **Chernewski, Eleonora** *(Dept. of Occupational Therapy, Univ. of Pennsylvania, Philadelphia 4, Pa.)*

The social determinants of mental illness and psychosomatic disease. *Am. J. Occupational Ther.* Sept.-Oct., 1961. 15:5:193-195.

A review of the literature regarding areas of culture, personality, and status and their influence on psychological and somatic illness. Social sanction and the prestige value and respectability of illness as a form of retreat from the environment are cultural factors in the acquisition and prolongation of illness. Such personality factors as inability to express aggression, the need for dependency, and a special type of deviant behavior may also delay recovery. Social class and social mobility affect the individual's set of values and attitudes, which, in turn, can determine how he will react to illness. A summary of a paper presented in partial fulfillment of the requirements for the M.A. degree, University of Southern California. 23 references.

973. **Shatin, Leo** *(436 Mountain Ave., Westfield, N.J.)*

Psychological remotivation of the chronically ill medical patient; a quantitative study in rehabilitation methodology, by Leo Shatin, Paula Brown, and Marion Loizeaux. *J. Chronic Diseases.* Oct., 1961. 14:4:452-468.

At Albany VA Hospital, 3 rating scales were used to judge behavioral adjustment to the ward, activity participation, and morale and attitudes in an experimental group (39) and a control group (14). Construction of the scales and their use are described. Data obtained from all 3 scales indicated a significant rise in superiority of the experimental over the control group. The rehabilitation program included: nursing service; occupational, manual arts, corrective, and music therapies; recreation, library, psychology, social, and volunteer services; and chaplain services.

See also p. 365.

PUBLIC HEALTH—STUDY UNITS AND COURSES

See 988.

PUBLIC HEALTH NURSING—CALIFORNIA

974. **Brandt, Edna J.** *(California State Dept. of Public Health, Bur. of Nursing, 2151 Berkeley Way, Berkeley 4, Calif.)*

A home nursing service in a rural county, by Edna J. Brandt (and others). *Am. J. Public Health.* Sept., 1961. 51:9:1294-1305.

Describes the organization and administration of a 3-year experimental project providing home nursing services in a rural agricultural county (Modoc County, Calif.). Statistical data on characteristics of patients served, utilization of nursing visits and types of services given, administrative costs, and community acceptance of the service are included. A large percentage of those served were elderly persons with chronic diseases who could utilize skills of a full rehabilitation team.

REHABILITATION

See 990; p. 358.

REHABILITATION—GERMANY

See 910.

REHABILITATION—ADMINISTRATION

975. **Randle, A. P. H.** *(Garston Manor Med. Rehabilitation Centre, Watford, Herts., Eng.)*

Some medico-social problems of rehabilitation. *Lancet.* Sept. 16, 1961. 7203:647-649.

Of the 381 patients discharged from a rehabilitation center in 1958, 245 were found to be working by the end of 1959; 44 not working were considered able to do so. Reasons given by patients for their unemployment were charged to delays in starting work following discharge, loss of income by working (wages less than welfare allowances), delay in settlement of compensation cases, and family attitudes of overprotection. Other roadblocks to successful rehabilitation and re-employment were: lack of communication between medical units and other social agencies, need for sheltered workshops to meet local employment demands, and rigid rules and regulations set by governmental authorities and trade unions.

976. **Wylie, Charles M.** *(615 N. Wolfe St., Baltimore, Md.)*

Delay in seeking rehabilitation after cerebrovascular accidents. *J. Chronic Diseases.* Oct., 1961. 14:4:442-451.

An analysis of records of 612 patients who applied for admission to Montebello Chronic Disease Hospital, Baltimore, during 1956 through 1959 showed that delay in seeking rehabilitation was related to certain characteristics of each patient. Data are broken down according to age, sex, race, marital and financial status, and severity of disability produced by cerebrovascular accident. Short delay was associated with those 75 years or older, females, nonwhites, and those without a living spouse. Findings by income group were less consistent. Long delay was associated with severity of disability on admission but the finding was not conclusive. Pattern of delay was believed compatible with the hypothesis that socioeconomic problems, rather than desire for rehabilitation, were the major reason for applying for care.

See also 909.

REHABILITATION—EQUIPMENT

977. Kenny Rehabilitation Institute

Selected equipment useful in rehabilitative nursing in the hospital, nursing home, or at home. Minneapolis, The Institute, 1961. 14 p. illus.

Illustrated and described are 12 items of equipment, with instructions for their construction or installation and suggestions for their use. Includes ramp; sliding board; lap board; sling; bathroom handrails and raised toilet seat; shoulder, hand, and trochanter rolls used in the prevention of deformity; footboards; bed rails; and bedboard and mattress.

Distributed by The Kenny Rehabilitation Institute, 1800 Chicago Ave., Minneapolis 4, Minn.

REHABILITATION—PROGRAMS

978. Mod. Hospital. Oct., 1961. 97:4:90-105.

Special section on rehabilitation.

Contents: How hospitals can help the disabled, Mary E. Switzer.—Activity gives hope to handicapped.—They give ability back to the disabled.—Rehabilitation bridges gap between hospital and home, M. T. F. Carpendale.—Why nursing homes need volunteers, Anne Gross.—Rehabilitation goes home with the patient, Earl F. Hoerner.

Articles in this section all describe new approaches to rehabilitation and their value in the hospital and nursing home. Miss Switzer discusses federal aid to hospital rehabilitation programs and training programs for professional personnel. Services at the National Jewish Hospital, Denver, the University of Florida's Rehabilitation Center, Gainesville, and the University of Alberta Hospital, Edmonton, Canada, are used to illustrate administration of rehabilitation departments. Mrs. Gross, director of volunteer services, Mt. Zion Hospital and Medical Center, San Francisco, urges the extension of rehabilitation services to proprietary and nonprofit nursing homes. Dr. Hoerner describes a continuation care (home care) program, part of the comprehensive rehabilitation program of The Hospital Center of Orange, N.J.

RELIGION

See 904; 905; 959.

SHELTERED WORKSHOPS—CANADA

See 918.

SPECIAL EDUCATION

979. Jordan, Thomas E. *(Dept. of Education, St. Louis Univ., St. Louis, Mo.)*

Conceptual issues in the development of a taxonomy for special education. *Exceptional Children.* Sept., 1961. 28:1:7-12.

Those in special education can no longer use precedent as a rationale for methods of instruction and child study. A taxonomy, defined as a conceptual model reflecting in its categories either a broad or narrow range of concerns, is needed as a research tool for describing and communicating the processes of instruction. When special education has developed comprehensive data language, then the development of a comprehensive taxonomy will occur. Practical application of such a tool in curriculum planning, in communication of ideas between different disciplines, and in unifying theory and practice is discussed.

SPECIAL EDUCATION—CALIFORNIA

980. Randall, Harriett B. *(450 N. Grand Ave., Los Angeles, Calif.)*

Disabled pupils and the new decade. *J. School Health.* Oct., 1961. 31:8:252-261.

The medical director of the Los Angeles City Schools reviews recommendations of the White House Conference on Children and Youth that are relevant to schools and particularly to disabled children. Services and facilities operating in Los Angeles are evaluated to determine current gaps in providing for the needs of the emotionally handicapped, the physically or socially handicapped, and the mentally retarded. The section on services for the physically handicapped is especially detailed. Suggestions for improving school programs for these children are offered. Dr. Randall's paper was presented at a joint meeting of the American School Health Association and the American Public Health Association in November, 1960.

SPECIAL EDUCATION—PROGRAMS

981. Wallace, Helen M. *(U.S. Children's Bur., Washington 25, D. C.)*

School services for physically handicapped children in urban areas. *Arch. Phys. Med. and Rehab.* Sept., 1961. 42:9:631-638.

Containing essentially the same information as an earlier article by Wallace and Starr (see *Rehab. Lit.,* May, 1960, #380), the current analysis of findings of a 1958 survey is limited to services for children with orthopedic, neuromuscular, or neurologic conditions. It does suggest 10 specific recommendations for overcoming the wide variation in services found in communities of 100,000 population or more.

The editorial by Frederic J. Kottke (p. 629-630) in this issue points out the lack of co-ordination in programs for medical care and education of the physically handicapped. He notes that in only one school system did a physiatrist participate in the review of applications for special educational placement of such children. Co-operation of physiatrists and vocational rehabilitation counselors could lead to the development of total rehabilitation programs.

See also 903.

SPEECH CORRECTION

982. D'Asaro, Michael J. *(Dept. of Speech, Univ. of California, Los Angeles 24, Calif.)*

A rating scale for evaluation of receptive, expressive, and phonetic language development in the young child, by Michael J. D'Asaro and Vera John. *Cerebral Palsy Rev.* Sept.-Oct., 1961. 22:5:3-4, 17-19.

An article reporting on revision of the extended language development scale, prepared by D'Asaro, Lehrhoff, Zimmerman, and Jones and originally presented to the American Academy for Cerebral Palsy in 1956. Receptive and expressive portions of the scale are discussed here; the phonetic portion will be reported separately. The revised form of the scale is included. Preliminary findings of the standardization study of the scale reveal the expected pattern of adequate grading of difficulty in items. Used

in a diagnostic setting with 34 speech handicapped children, the test resulted in scores that correlated significantly with those from the Vineland Scale of Social Maturity. Comments and suggestions on the application of the revised scale are needed in the continuing study.

983. Falck, Frank J. *(Univ. of Vermont Coll. of Medicine, Burlington, Vt.)*

Communicative disorders; a multidisciplinary problem, by Frank J. Falck and Vilma T. Falck. *J. Am. Med. Assn.* Oct. 21, 1961. 178:3:290-295.

A review of the statistics on estimated incidence and prevalence of speech and hearing problems in the U.S. and of results of a University of Vermont study of 1,600 elementary and high school students reveals that the extent of the problem is great enough to warrant serious attention. Disorders of communication in both children and adults call for proper direction; this article discusses appropriate referral procedures, facilities available for providing diagnostic and rehabilitation services, and the speech, hearing, and language problems. Since the physician is often the first source of help contacted, it is necessary that he be informed on community resources and services.

See also 971.

SPORTS

984. Jokl, Ernst *(Univ. of Kentucky, Lexington, Ky.)*

Neurological case history of a champion athlete. *J. Assn. for Phys. and Mental Rehab.* Sept.-Oct., 1961. 15:5:134-142.

Studies in clinical physiology of exercise, VI.

Dr. Jokl discusses the case history of Mrs. Lis Hartel, double Olympic Silver Medal Winner and European Champion in Equestrian Dressage Contest, who suffered an attack of poliomyelitis 17 years ago that resulted in extensive bilateral paretic and paralytic sequelae. All 4 extremities were affected. Includes a chart of the clinical evaluation of Mrs. Hartel's muscle functions as of March, 1961, and a discussion of her achievements from the neurophysiological point of view. Dr. Jokl believes effective rehabilitation is possible only in those individuals who have set their own goals and that goals are not "biologically" fixed. The challenge of rehabilitation, he says, appeals to the "spirit of man."

THROMBOANGIITIS OBLITERANS

985. Policoff, Leonard D. *(Albany Med. Center Hosp., Albany 8, N.Y.)*

The management of the patient with arterio-sclerosis obliterans. *Arch. Phys. Med. and Rehab.* Aug., 1961. 42:8:584-589.

Of the wide variety of therapeutic technics in long-term management of patients with arteriosclerosis obliterans, many are useless and may even be detrimental to their welfare. Physical therapy is more often abused than neglected in the treatment plan; drug therapy and sympathectomy have a very limited place in management. Scrupulous attention should be paid to cleanliness, warmth, and avoidance of trauma. Walking daily within pain limits is the therapy of greatest value, as it tends to produce collateral vascular channels that may have long-term beneficial effects for the patient. Where amputation becomes necessary, a decision should be reached before surgery on the type of prosthesis to be used.

TYPING

986. Cohoe, Edith *(Dept. of Special Education, Detroit Board of Education, 453 Stimson Ave., Detroit 1, Mich.)*

Typewriting instruction for partially seeing and blind children. *Exceptional Children.* Sept., 1961. 28:1:13-17.

A supervisor of classes for the blind and partially seeing describes adaptations and adjustments of ordinary typewriting to the needs of the visually handicapped, the great majority of whom are ready to learn this skill when they reach the fourth grade. Muscle control and coordination of the individual child must be considered. Instructions for the teacher and a checklist of points to watch in presenting and carrying through on lesson plans are included.

VISION

987. Fletcher, Mary C. *(906 Medical Towers, Houston, Tex.)*

Eye abnormalities in the mentally defective, by Mary C. Fletcher and Mary Martha Thompson. *Am. J. Mental Deficiency.* Sept., 1961. 66:2:242-244.

Complete eye examinations were given 102 mentally retarded children and adults enrolled in the day school and sheltered workshop of the Houston Council for Retarded Children during 1957-1958; the majority were classified as trainable. Statistics on eye abnormalities found are included. Five matched pairs were selected as a treatment group and control group; no improvement in performance in the objective psychological tests was demonstrated by any of the subjects in either group. Two showed improved behavior at home, at school, and in the sheltered workshop. It is possible that future development of the children may be altered. Improved vision at an early age (1 to 4 years) may help prevent confusion and poor contact with the environment, thus promoting better adjustment.

VOCATIONAL GUIDANCE

See 906; 909; 916; 917; 944; 945; 946; 954.

VOLUNTARY HEALTH AGENCIES

988. American Public Health Association. Western Regional Office

The voluntary health agency; meeting community needs. San Francisco, Program of Continuing Education, Western Regional Off., Am. Public Health Assn., 1961. 50 p. *(Continuing Education monographs, no. 1)*

The Program of Continuing Education in Public Health, a cooperative effort of the University of California Schools of Public Health, Western Regional Branch of the American Public Health Association, and the national organization of the Association, provides professional public health workers opportunity to learn of new trends and developments in the field. The papers in this monograph were presented as part of the Course for Voluntary Health Agency Personnel, June, 1960-June, 1961. Designed to make university level education in the field available to

working personnel who have already received basic professional education, the program offers courses flexible in format, to meet local needs and conditions.

Contents: Philosophy and significance of the voluntary health agency movement, Dalrie S. Lichtenstiger.—Planning in the voluntary health agency to meet the health needs of the community, David DeMarche.—Beyond the principles; a short course in organization theory, Julian Feldman.—Health education and community action, Beryl J. Roberts.—Behavior in groups; some principles of group process, Dorothy B. Nyswander.—The consultative process, Hugh T. Croley.—Cultural factors influencing community health, J. Albert Torribio.

Available from Western Regional Office, American Public Health Assn., 693 Sutter St., San Francisco 2, Calif., at $1.00 a copy (25% discount available to agency members of the Association). This first monograph of the new series will be followed by others, each containing the principal papers delivered during courses.

WALKING

989. Knocke, Lazelle *(Lenox Hill Hosp., 111 E. 76th St., New York 21, N.Y.)*

Crutch walking. *Am. J. Nursing.* Oct., 1961. 61:10: 70-73.

Explains technics nurses should be acquainted with in teaching crutch walking, mainly to those who will be using crutches on a temporary basis. Basic principles of management, the psychological and physical preparation of patients who will need crutches, types of crutches and their fitting, and types of gait in relation to patients' weight-bearing status are discussed. Article is illustrated. Mrs. Knocke was coauthor of "Orthopaedic Nursing," issued in 1951 by F. A. Davis, Publishers; a 2d edition is in preparation.

WORKMEN'S COMPENSATION

990. International Association of Industrial Accident Boards and Commissions

Workmen's compensation problems, 1960; proceedings, 46th annual convention of the . . . Edmonton, Alberta, August 21-25, 1960. Washington, D. C., U. S. Bur. of Labor Standards, 1961. 275 p. tables. *(Bul. 229)*

The Proceedings, containing committee reports, individual papers, exhibit information, and panel discussions, cover the many aspects of workmen's compensation, rehabilitation, employment, and current changes in legislation relating to workmen's compensation in Canada and the U. S. Articles of special interest include: Reconstructive surgery to hands and upper arms of partial quadriplegics, Gordon L. Wilson. p. 61-69.—Report of the Rehabilitation Committee, Antonio DiPinto. p. 85-93.—Panel discussion: Experience in handling low back strain, John R. Fowler, moderator; panel members, Reginald J. Milbank, Norman E. Hurl, Charles M. Norman. p. 94-111.—Rehabilitation of the industrially injured as administered in New York and a report on the findings of the New York University study on rehabilitation, Solomon E. Senior. p. 111-124.—The employer wants parity of risk, Vincent P. Hippolitus. p. 125-131.—Some comments on the Subsequent Injury Fund Survey, conducted Summer, 1960, Abram J. Jaffe. p. 209-217.—Ability to work after heart surgery, Robert S. Fraser. p. 239-242.

Events and Comments

Revised Employment Interviewing Guide on Epilepsy Issued

THE GUIDE ON EPILEPSY, which is part of a series *Interviewing Guides for Specific Disabilities,* originally introduced in 1953, has been reissued by the U.S. Bureau of Employment Security. The revision was done chiefly to emphasize employability of epileptics whose seizures are medically controlled and to present the most enlightened approach to their employment. The guide may prove a helpful tool in overcoming prejudice and misinformation that deter the hiring of epileptics.

Copies of the *Interviewing Guide (Epilepsy, rev. 1961, Neuropsychiatric Diseases 152)* may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C., at 5¢ a copy (25% discount on purchase of 100 or more copies).

Kennedy Names Study Panel On Mental Retardation

IN OCTOBER President Kennedy named a panel of 24 experts in various areas of medicine, business, sociology, psychology, law, and education to study mental retardation and make recommendations aimed at preventing and treating it. A report is requested as of Dec. 31, 1962. Leonard Mayo, executive director of the Association for the Aid of Crippled Children, is chairman of the panel, and George Tarjan, M.D., medical director of the Pacific State Hospital, Pomona, Calif., has been named vice chairman.

President Kennedy stated that intensive effort to solve the problem of mental retardation has been postponed too long, saying that about 5 millions in the United States are retarded, 4 percent being in institutions. The President has charged the panel with studying the possibilities of preventing and curing mental retardation and investigating related biological, psychological, educational, and vocational factors; the relation between the federal and state governments and private groups; and current programs of treatment, education, and rehabilitation.

Wallin Heads Pennsylvania Workshop for Retarded

J. E. WALLACE WALLIN, Ph.D., of Wilmington, Dela., has returned to active administrative duties as executive director of Industries Limited, of Carlisle, Pa. Dr. Wallin, now approaching 86 years of age, is the oldest surviving member of the original group of clinical psychologists and special educators in the United States.

Industries Limited is one of the oldest facilities in Pennsylvania for the purpose of evaluating, training, and employing or placing older adolescent and adult mental retardates. Dr. Wallin plans to investigate the use of objective technics for the assessment of potentialities in the field of psychomotor reactions and to revise the Wallin peg boards, the first psychological test specifically designed for the measurement of young children's psychomotor capacity.

New Rehabilitation Journal Published in Belgium

THE FIRST ISSUE of a new journal *Liaison*, dedicated to rehabilitation of the physically and mentally handicapped and published by the Fédération des Oeuvres d'Enseignement Spécial of the Province of Brabant, Belgium, replaces three previous journals—*Area, Persévérer,* and *Emancipation*. Four provincial agencies—La Ferme-Ecole de Waterloo, L'Institut pour Handicapés, L'Institut pour Sourds-Muets, Aveugles, et Amblyopes, and Le Centre Médico-Psycho-Social—are collaborating in publication of the new bilingual journal. *Liaison* will be issued quarterly. Inquiries regarding subscription costs should be directed to the Secretary, *Revue Liaison,* 75 Boulevard de la Révision, Brussels 7, Belgium.

Effects of Brain Disorder on Perceptual Motor Development Studied in California

A ONE-YEAR EXPERIMENTAL STUDY, "Perceptual Motor Development Problems with Those Severely Involved by Cerebral Dysfunction," under the auspices of the Spastic Children's Foundation *(1307 West 105th St., Los Angeles 44, Calif.)*, began on October 1st of this year.

A team of professionals representing inter-related educational and medical disciplines will attempt to segregate and isolate facts relative to poor or inadequate perceptual motor development. Problems pertinent to this development and the part it plays in learning abilities and skills, will be analyzed and recommendations made for methodology on training and educating those so inflicted.

The experimental and control groups consist of children with varying degrees of disability generalized as cerebral palsy, epilepsy, mental retardation, and behavioral disturbances that are residuals of insult to the brain. Each individual involved in the experimental and control groups of this study is multiply handicapped.

Robert E. Hall, executive director, and Anne M. Wendt, program director of Spastic Children's Foundation are codirectors for this project, with John Siepp, assistant to the program director, acting as co-ordinator. Caro Hatcher, Ed.D., associate professor in special education of Los Angeles State College, is in charge of psychological evaluations and interpretations and analysis of results. Eileen Wong, O.T.R., is in charge of perceptual motor training and evaluations.

Art Therapy Quarterly Begins Publication

VOLUME 1, NO. 1 of *The Bulletin on Art Therapy,* published in September, features the article "Art and Emptiness: New Problems in Art Education and Art Therapy," by Edith Kramer, with comment by Blanche Jefferson. The 32-page quarterly also features a book review, news, and listing of recent periodical literature and of courses in art therapy. A copy of this first issue (Fall issue, 1961) may be obtained by writing the editor Miss Elinor Ulman; editorial offices are at 634 A Street S.E., Washington 3, D.C. Subsequent issues are $3.00 yearly in the United States and $3.50 in other countires; single copies are $1.00.

Federation of Handicapped Appoints Director of Vocational Rehabilitation

THE FEDERATION OF THE HANDICAPPED *(211 W. 14th St., New York, 11, N.Y.)* has announced the appointment of Ida Alpert as director of vocational rehabilitation. For over 15 years, Miss Alpert was supervisor of the guidance division of the Federation Employment and Guidance Service, programs of which included services to retarded adolescents and to emotionally and physically handicapped persons.

The Federation plans to establish a pre-evaluation vocational center. At present the Federation is pioneering in a pilot project evaluating vocational potentialities of selected homebound adolescents, in co-operation with the U.S. Office of Vocational Rehabilitation, the New York State Division of Vocational Rehabilitation, and the New York City Board of Education.

The Pointer Begins Sixth Year of Publication

BEGUN SIX YEARS AGO as a mimeographed bulletin, *The Pointer* appeared in its Fall 1961 number as a printed journal. Although designed primarily for teachers of educable mentally retarded children, *The Pointer* has been found useful by teachers of children with other handicaps. Each issue is filled with brief articles giving practical suggestions on pupil activities and teaching units that contributors have successfully used. *The Pointer* is edited and published by Mrs. Carolyn Dobbs, 1714 Francisco St., Berkeley 3, Calif. Subscription rate: $3.50 a year for three issues; $1.50 a single copy.

A Comment on Mental Retardation and Social Work Education

"SOCIAL WORK education has major responsibility for instilling within the student an understanding of the nature and the manifestations of mental retardation as well as the realization that social work is one of several disciplines which has made a significant contribution to the prevention, diagnosis, and treatment of mental retardation, particularly in its social consequences. Moreover, social work education has responsibility for stimulating students to perceive the challenge of this field of service, for exercising leadership in expanding and advancing service to the retarded and their families, and for initiating, organizing, and conducting research in this field.

"Understanding of this kind can be comprehensively conveyed in the generic curriculum through a conscious emphasis that basic concepts apply to mentally retarded individuals as well as to any other individuals. These basic concepts include: the inter-relatedness of the bio-psycho-social factors which produce mental retardation; the dynamic nature of retardation and its consequent responsiveness to social intervention; the growth potential and the ability to change in the retarded individual; the existence of individual differences among the retarded.

"Social work practice in mental retardation has responsibility for providing a setting for field instruction in which students will have an opportunity to apply theory and to deepen and expand their knowledge in this field. Moreover, social work practice should provide educational opportunities for the graduate practitioner and aid research by making results of studies available to schools so that continued improvement of the curriculum can be achieved."—*From* Mental Retardation and Social Work Education; Proceedings of a Conference Held at Haven Hill Lodge, Milford, Michigan, June 16-19, 1959, *p. 5. Edited by Alfred H. Katz. 1961. 56 p. Wayne State University Press, Detroit 2, Mich. $1.50.*

Now available as a reprint is: "Parkinson's Disease: Rehabilitation Aspects," by R. S. Schwab and A. C. England, as published in the November issue. Address orders to *Rehabilitation Literature*. 25¢ ea.

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Author Index

The Annual Index for Vol. 22, 1961, will be issued with the January, 1962, issue of *Rehabilitation Literature*.